

International Waiver Application

UW-Madison Student Health Insurance Plan
University Health Services
333 East Campus Mall-7th Floor
Madison, WI 53715-1381
Phone (608) 265-5232
Fax (608) 265-5668
www.uhs.wisc.edu
shipmail@uhs.wisc.edu

IMPORTANT INFORMATION – PLEASE READ CAREFULLY

It is a condition of enrollment that all international students and J-1 scholars are required to purchase the UW-Madison Student Health Insurance Plan (SHIP) or file a qualifying waiver. **Waivers will only be granted for international students and J-1 scholars who satisfy one of the criteria listed under the INSURANCE SECTION on the reverse of this Waiver Application. Individual and private insurance plans DO NOT qualify for a waiver. Remember: If you do not qualify for a waiver, you are required to enroll in SHIP.**

In order to waive out of the University-sponsored health plan, international students and J-1 scholars must complete this application and submit it to the SHIP office by the specified deadlines. For international students, this Waiver Application must be submitted by September 15th in Fall, February 15th in Spring/Summer or within 30 days of the date of the first registered class for new Summer students. J-1 scholars must submit this Waiver Application within 30 days of their arrival in the United States. If the DS-2019 is not effective until after the arrival date, the J-1 scholar must submit this Waiver Application within 30 days of the DS-2019 start date. Transferring J-1 scholars must submit this Waiver Application within 30 days of their arrival at UW-Madison. J-1 scholars who extend their stay at UW-Madison must submit this Waiver Application within 30 days of their extension date.

Renewing J-1 scholars must submit this Waiver Application within 30 days of their current end date.

International students and J-1 scholars who fail to register by the stated deadline will be charged a late fee of \$50. A hold will also be placed on the academic records of non-compliant international students. J-1 scholars could be denied travel visas and visa extensions until they are compliant.

International students or J-1 scholars that acquire qualifying insurance after the stated deadline can still apply for a waiver by submitting this Waiver Application within 30 days of the effective date of the new policy. If this 30-day deadline is missed, a late fee of \$50 will be applied in addition to any required premiums.

Note: International students who are graduate assistants and have coverage through a Wisconsin state health insurance plan (Group Health Cooperative; Unity Health Plans; Physicians Plus; Dean Health Care or Standard Plan) do not need to submit this Waiver Application as long as they are the primary subscriber (not a dependent) and the insurance is effective on or before September 1 for Fall, or February 1 for Spring. The SHIP office will file an automatic waiver on your behalf.

Note: International students who are also dependents on a Wisconsin state health insurance plan cannot be identified for an automatic waiver by the SHIP office, and must submit this Waiver Application.

All other international students and J-1 scholars must complete this Waiver Application and submit it along with a copy of the front and back of the health insurance ID card and/or written verification of coverage by fax to (608) 265-5668, by mail or in person at University Health Services, 333 East Campus Mall-7th Floor, Madison, WI 53715-1381. Once your Waiver Application has been reviewed a decision notification will be e-mailed to you.

I acknowledge that by submitting this form, I am waiving out of SHIP and certify that:

- *I satisfy one of the criteria listed under the insurance section for the required period.*
- *I understand that if there is a gap of 17 days or less between the beginning of the SHIP compliance period and the effective date of my qualifying waiver, I will not be required to enroll in SHIP for that period. I understand that if the gap is greater than 17 days, I will be responsible for a minimum of 1 month of SHIP premiums to cover the interim period. I understand that SHIP coverage is retroactive from the policy effective date.*
- *I understand that if I experience an involuntary loss of insurance during the waived period I must enroll in SHIP. I understand that failure to notify the SHIP office and enroll in SHIP within 30 days of the loss of insurance will result in a late fee of \$50 in addition to any required premiums.*
- *I will be solely responsible for all medical expenses, and neither UW-Madison nor SHIP, will be held responsible for any medical expenses that I incur.*
- *I understand that information provided herein is confidential and will be used for the sole purpose of documenting my decision to waive out of SHIP and will not be made available to any third party.*
- *I am also granting UW-Madison the permission to verify this information through an auditing process. I understand that all waiver approval or denial decisions are made at the sole discretion of University Health Services. If it is determined that the information provided on this form is invalid, I understand that I will be enrolled into and billed for SHIP coverage for the relevant semester and may also be subject to a late fee of \$50 in addition to any required premiums.*

PLEASE PRINT LEGIBLY

<input type="checkbox"/> International Student <input type="checkbox"/> New J-1 Scholar <input type="checkbox"/> Renewing J-1 Scholar <input type="checkbox"/> Extending J-1 Scholar (Please Select)			
University ID Number (10 digits)	First Name	Middle Initial	Last Name
Local Address Line 1		Local Address Line 2	
City	State	Zip Code	Local Phone
E-mail Address:		Birth Date (month/day/year)	<input type="checkbox"/> Female <input type="checkbox"/> Male

J-1 SCHOLAR SECTION (to be completed by J-1 scholars only)	
Please provide a copy of your current DS-2019 which must include your stamped arrival date into the United States or the start date of your visa extension.	Dept Name: _____
Arrival Date: _____	Dept Contact Person: _____
Departure Date: _____	Phone Number: _____

INSURANCE SECTION (to be completed by all applicants)
I certify that I satisfy one of the following criteria (A, B, C or D) and that health coverage will remain in effect through the current semester, academic year or DS-2019 end date:
<p>A. I am covered as a <u>main member</u> of a Wisconsin state health insurance plan provided by UW-Madison Please check box: <input type="checkbox"/> GHC <input type="checkbox"/> Dean Health Plan <input type="checkbox"/> Unity <input type="checkbox"/> Physicians Plus <input type="checkbox"/> Standard Plan</p> <p>B. I am covered as a <u>dependent</u> on a Wisconsin state health insurance plan provided by UW-Madison Please check box: <input type="checkbox"/> GHC <input type="checkbox"/> Dean Health Plan <input type="checkbox"/> Unity <input type="checkbox"/> Physicians Plus <input type="checkbox"/> Standard Plan Primary Member Name: _____ Primary Member University ID: _____</p> <p>C. I am covered by a US-based group plan (not through UW-Madison) as an employee, or dependent of an employee Name of Employer: _____ Name of Insurance Plan: _____</p> <p>D. I am covered under one of the following organizations which has a waiver agreement with the SHIP office (please check the relevant box):</p> <p><input type="checkbox"/> Embassy of Kuwait <input type="checkbox"/> Embassy of Oman <input type="checkbox"/> Embassy of Qatar <input type="checkbox"/> Fulbright Scholars (USDOS) <input type="checkbox"/> Norwegian National Insurance Scheme <input type="checkbox"/> Royal Embassy of Saudi Arabia <input type="checkbox"/> Swedish State Insurance <input type="checkbox"/> Royal Thai Embassy Office of Educational Affairs <input type="checkbox"/> Engineering off-campus students <input type="checkbox"/> Malaysian Government <input type="checkbox"/> Master of Engineering On-line Program <input type="checkbox"/> Laboratory Quality Management On-line Graduate Program <input type="checkbox"/> University of Maryland (International Scholarship Program) <input type="checkbox"/> Government of the United Arab Emirates <input type="checkbox"/> Embassy of Italy (Italian Government Employees) <input type="checkbox"/> University of Maryland (International Scholarship Program) <input type="checkbox"/> German Academic Exchange Service (DAAD New York) <input type="checkbox"/> Libyan Embassy <input type="checkbox"/> International students/scholars studying or researching outside the United States (departmental verification required) <input type="checkbox"/> Students with visa documentation issued by another educational institution in the United States (I-20/DS-2019 verification required)</p>
Please note that this Waiver Application cannot be approved unless it is accompanied by a copy of the front and back of the health insurance ID card and/or written verification of coverage. If you are unable to obtain the required documentation, please notify the SHIP office immediately.

X _____	_____
Student/Scholar Signature of Understanding	Date (month/day/year)
For further information regarding SHIP policies and procedures, please refer to our web-site: www.uhs.wisc.edu/ship	

FOR OFFICE USE ONLY:					
<input type="checkbox"/> Waiver Approved	<input type="checkbox"/> Late Fee Applied	<input type="checkbox"/> Late Fee Paid	<input type="checkbox"/> Cancel Late Fee	<input type="checkbox"/> Remove Holds	<input type="checkbox"/> Scholar on HPAD
Waiver Effective	Waiver Termination	Insurance Start	Insurance End	Staff ID	Date Approved
<input type="checkbox"/> Waiver Denied <input type="checkbox"/> Hold Removed Waiver Processed By: _____					Notes: _____