INTERNATIONAL J-1 SCHOLAR WAIVER APPLICATION

Student Health Insurance Plan
University Health Services
333 East Campus Mall
Madison, WI 53715-1381

WISCONSIN
UNIVERSITY OF WISCONSIN–MADISON

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This Waiver Application is for visiting scientists, professors, postdoctoral fellows, and students in academic training who completed their program of study, or non-degree research project students on a J-1 visa who are NOT registered for classes.

All J-1 Scholars and J-2 dependents are required to have UW-Madison approved health insurance coverage. This requirement is administered by the UW-Madison Student Health Insurance Plan (SHIP) office – a unit of University Health Services. J-1 Scholars must purchase SHIP for themselves and any J-2 dependents or file a qualifying waiver. **Waivers will only be approved for J-1 Scholars and J-2 dependents who meet one of the criteria listed under the INSURANCE SECTION on this Waiver Application. Individual and private insurance plans (including travel insurance and Marketplace plans) DO NOT qualify for a waiver.**

Qualifying waivers must be filed at the SHIP office by the following deadlines:

UW-Madison Health Insurance Compliance Deadlines
New J-1 Scholars: within 31 days of the later of the DS-2019 start date, arrival date, or transfer date
Renewing J-1 Scholars: within 31 days of the waiver/SHIP coverage end date
Extending J-1 Scholars: within 31 days of the waiver/SHIP coverage end date

J-1 Scholars who fail to file a qualifying waiver or enroll in SHIP by the compliance deadline may be charged a late fee of $100 in addition to any required SHIP premiums.

All completed Waiver Applications must be submitted along with a copy of the front and back of the health insurance ID card and/or written verification of coverage by email to: shipmail@uhs.wisc.edu. *Incomplete Waiver Applications will not be accepted.* If your documents are not in English, you will be required to have them translated. Once your Waiver Application has been reviewed a decision notification will be emailed 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 of the Waiver Application for the required period.*

- *I understand that if there is a gap between the beginning of the compliance period and the effective date of my qualifying insurance coverage, I will be required to enroll in SHIP from the beginning of the compliance period up until the effective date of the waiver. I understand that waivers are effective from the 15th of the month following the active qualifying insurance coverage start date.*

- *I understand that if I enroll in SHIP and then file a qualifying waiver that covers part or all of the same period, I will only be eligible for a refund of SHIP premiums from the 15th of the month following SHIP office verification of active qualifying insurance coverage.*

- *I understand that if my qualifying insurance coverage ends during the waived period I must enroll in SHIP or file another qualifying waiver within 31 days of the insurance end date. I understand that if there is a gap between the end date of the previous qualifying insurance coverage and the effective date of my new qualifying insurance coverage, I will be required to enroll in SHIP from the beginning of the 31-day compliance period up until the effective date of the new waiver. I understand if I do not qualify for another waiver, I will be required to enroll in SHIP from the beginning of the 31 day compliance period.*

- *I understand that it is my responsibility to file a new Waiver Application by the compliance deadline following the waiver end date if I still have active qualifying insurance coverage at that time.*

- *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 understand that UW-Madison may 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 coverage period and a $100 late fee may be payable in addition to any required premiums.*

APPLICANT INFORMATION

(Select) ☐ **New J-1 Scholar** ☐ **Renewing/Extending J-1 Scholar**

University ID Number	First Name	Middle Initial	Last Name

Local Address	Apt. Number	City	State	Zip Code

E-mail Address:	Contact Phone	Birth Date (month/day/year):	☐ Female ☐ Male

J-VISA DEPENDENT INFORMATION: Please provide a copy of stamped passports and DS-2019s

First Name	Middle Initial	Last Name	☐ Spouse / Partner
First Name	Middle Initial	Last Name	☐ Child
First Name	Middle Initial	Last Name	☐ Child

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 insurance coverage will remain in effect through the current semester, academic year, or DS-2019 end date:

A. I am covered as a <u>main member</u> of a Wisconsin state health insurance plan provided by UW-Madison
☐ GHC   ☐ Dean Health Plan   ☐ Quartz - UW Health   ☐ Access Plan by Dean Health Plan
Please be advised that the High Deductible Health Plan (HDHP) coverage option <u>does not</u> qualify for a waiver

Note – if you receive Wisconsin state health insurance through a paid appointment, you have 30 days from your appointment start date to sign-up for that coverage. For more information, contact your department admin.

B. I am covered as a <u>dependent</u> on a Wisconsin state health insurance plan provided by UW-Madison
☐ GHC   ☐ Dean Health Plan   ☐ Quartz - UW Health   ☐ Access Plan by Dean Health Plan   ☐ SHIP
Primary Member Name: _____ Primary Member University ID: _____

Please be advised that the High Deductible Health Plan (HDHP) coverage option <u>does not</u> qualify for a waiver

C. I am covered by a US-based group health plan (not through UW-Madison) as an employee, or dependent of an employee
Name of Employer: _____ Name of Insurance Plan: _____

D. I am covered under one of the following organizations which has an active waiver agreement with the SHIP office

☐ Embassy of Kuwait / Cultural Division   ☐ Embassy of Oman / Cultural Division   ☐ KAUST Gifted Student Program

☐ Royal Thai Embassy (OEA)   ☐ Saudi Arabia Cultural Mission (SACM) *(Financial Guarantee Letter required)*   ☐ Student Scholarship Program (SSP) of SABIC

☐ Embassy of the United Arab Emirates - Education & Technology Sciences Attaché

Please note that this Waiver Application cannot be accepted 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. I acknowledge that by submitting this form, I am waiving out and certify that I understand and have carefully read Page 1 and Page 2 of this Waiver Application.

X _____   _____
       Scholar Signature of Understanding   **Date** (month/day/year)

THIS SECTION - FOR SHIP OFFICE USE ONLY

☐ Waiver Denied (Scholar notified)		☐ Waiver Accepted	☐ Page 1 Given	Staff ID:		Date:
☐ Late Fee Applies:	☐ Late Fee Paid (Payment Only Form Attached)		☐ Late Fee Applies but Not Paid			

SHIP Effective	SHIP End /14/	☐SHIP Paid	☐ SHIP Not Paid	**Waiver Eff.**	**Waiver End**	Other Ins. Start	Other Ins. End
J-1 Scholar Later of DS-2019 Start/Arrival			Waiver Entered by:			Other Ins. Coverage Verified by:	
J-1 Scholar DS-2019 End							