INTERNATIONAL STUDENT WAIVER APPLICATION
FALL STUDENTS

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

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This Waiver Application is for international students **registered for classes** at UW-Madison with an active non-immigrant status (such as F-1, J-1, H-1, etc.).

All International Students and visa 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. International students must purchase SHIP for themselves and any visa dependents or file a qualifying waiver. **Waivers will only be approved for International Students and visa 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 by email with the SHIP office by the following deadlines:

International Student Compliance Deadlines
Fall: September 14, 2026
NOTE: International Students who are employed at UW-Madison and have coverage through a Wisconsin State Health Insurance Plan do not need to file this Waiver Application as long as they are the main member and the insurance is effective on or before September 1, 2026. **If these criteria are met the SHIP office will file an automatic waiver on your behalf.**

International students who fail to file a qualifying waiver or enroll in SHIP by the compliance deadline will be charged a late fee of $100 in addition to any required SHIP premiums. *Note: International students who meet the criteria for an automatic waiver will not be subject to any late fee charges.*

All completed Waiver Applications must be submitted along with a copy of the front and back of the health insurance ID card and a current, dated Certificate 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 of 31 days or less between the beginning of the SHIP compliance period and the effective date of my qualifying insurance coverage, I will not be required to enroll in SHIP for that period, but I may do so if I wish.*
- *I understand that if there is a gap of greater than 31 days between the beginning of the SHIP compliance period and the effective date of my qualifying insurance coverage, I will be required to pay SHIP premiums 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 if I do not qualify for another waiver, my SHIP coverage will be effective from the beginning of the 31-day compliance period. I understand if I do not qualify for another waiver and fail to enroll in SHIP within 31 days, a $100 late fee will be payable in addition to any required SHIP premiums.*
- *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 will be payable in addition to any required premiums.*

APPLICANT INFORMATION				
☐ **International Student**				
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	

VISA DEPENDENT INFORMATION: Please provide a copy of stamped passports and DS-2019s or I-20s			
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, D, E or F**) 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 main member 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 does not qualify for a waiver

B. I am covered as a dependent 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 does not 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 studying or researching outside the United States (Academic Advisor or Departmental Verification required.)

E. ☐ My visa is issued by another educational institution or an employer in the U.S. (I-20, DS-2019 or I-797 required)

F. ☐ 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
☐ Master of Engineering On-line Program
☐ Embassy of the United Arab Emirates - Education & Technology Sciences Attaché
☐ United Arab Emirates Scholarship Office (SCO)
☐ The SABIC Scholarship Program (SSP)

Please note: this Waiver Application cannot be accepted unless it is accompanied by a copy of the front and back of your health insurance ID card and a current, dated Certificate of Coverage (that includes the effective date of your insurance). 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 of SHIP and certify that I understand and have carefully read Page 1 and Page 2 of this Waiver Application.

X _____ _____

International Student 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