New York University
Student Health Insurance
726 Broadway, Suite 346
New York, NY 10003
212-443-1020

F-1/J-1 STUDENT HEALTH INSURANCE WAIVER APPLICATION
STUDENT ACKNOWLEDGMENT & INSURANCE PROVIDER CERTIFICATION FORM

Section A must be completed by student

A _____

Last Name, First Name | Student ID# | Birthdate (mm/dd/yyyy)

I acknowledge that New York University (NYU) policy requires international students to provide evidence of all-inclusive health insurance while registered at the University. I acknowledge that it is my responsibility to choose my own health insurance carrier and to obtain the carrier's certification that the plan meets specific minimum coverage requirements. **Please read all of the terms, conditions and exclusions first before purchasing any other product.** I further acknowledge my responsibility to maintain insurance coverage and to submit this form at each and every renewal or change of carrier. Further, I understand that the NYU required minimum coverage levels may change each year and that I am responsible for updating my insurance in keeping with the stated requirements.

I certify that I am covered by all-inclusive health insurance as described below. I promise to maintain this level of health insurance throughout the time I am registered at NYU. I acknowledge and agree that NYU is not responsible for my health insurance or medical expenses. If I have dependents, all of my certifications, promises, acknowledgments, and agreements extend to my dependents as well as myself.

_____

Student Signature | Date | email address

Section B must be completed by the health insurance company representative:

Name(s) of insured individual(s):

B _____ _____

Print Full Name | P rint Full Name

Insurance Carrier: _____

Member Insurance ID#:_____ **Dates*:**_____ to_____
mm/dd/yyyy mm/dd/yyyy

***While enrolled at NYU, you are required to have all-inclusive health insurance.**

The plan/policy must meet ALL of the following minimum coverage requirements (all amounts are in USD). ***Agent: initial each line that meets coverage requirements.***

_____ Health insurance coverage must be **UNLIMITED** per accident/illness
_____ Inpatient/Outpatient medical/surgical coverage
_____ Inpatient/Outpatient mental health, substance abuse and alcohol related illness or injury coverage
_____ Repatriation coverage must be at least $25,000 USD
_____ Medical evacuation coverage to home country must be at least $50,000 USD
_____ No more than $1,500 USD deductible per policy year
_____ No waiting period for pre-existing conditions
_____ Headquartered and operating in the US with a US claims address and customer service telephone number

I certify that the minimum coverage requirements stated above are provided by this policy/plan.
I am qualified to make this determination as an authorized agent/employee of the above insurance provider.

_____

Print Name | **Contact Information (email and/or phone number)** | **Company/Agency**

_____

Signature | **Title** | **Date**