

## 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# (N#)	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

\_\_\_\_\_

Print 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 in the New York City area
- \_\_\_\_\_ Inpatient/Outpatient mental health, substance abuse and alcohol related illness or injury coverage in the New York City area
- \_\_\_\_\_ 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
-----------	-------	------