# **Student & Scholar Health Insurance Program Waiver**

To **WAIVE** medical benefits under the ISU Student and Scholar Health Insurance Plan, please read, complete, and return this Waiver Request Form (and required documentation, if necessary) to the Student Health Insurance Program within 31 days of the semester OR within 31 days of a qualifying event.

### *PLEASE PRINT THE FOLLOWING INFORMATION*

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | |  | | | | |
| Name: | |  | | | | |
|  | |  | | | | |
| University ID Number: | |  | | | | |
|  | |  | | | | |
| ISU Email Address: | |  | | | | |
|  | |  | | | | |
| Visa Type: |  | | Issue Date: |  | Expiration Date: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| ***Select each box that applies to your current student status:*** | | | |
|  | Undergraduate or Graduate Student Without Assistantship |  | Graduate Student With Research/Teaching/Admin Assistantship |
|  | Domestic |  | International |
|  | Sponsored (attach current Financial Guarantee) |  | H-4, L-2, H-1B Visa Status or Approved OPT with Employment |
|  | Exchange (attach Home University Insurance Certificate) |  | Fulbright (attach Terms of Appointment) |
|  | ISU Plan Spouse/Dependent |  | Other (contact our office for additional information) |

***BY SIGNING THIS WAIVER REQUEST FORM, I UNDERSTAND THAT:***

* A waiver will not be granted if any of the following occur:
  + Information provided is not fully complete or accurate;
  + The coverage under my current insurance plan lapses;
  + Information is presented to UHR after the waiver request deadline of 31 days.
* Iowa State University will not compensate me in exchange for waiving my right to this benefit.
* I am responsible for advising the Student Health Insurance Program (in writing) of any termination, lapse, or cancellation of my coverage; and, if any of these events occur, I am required to enroll in the ISU Student and Scholar Health Insurance Plan or I will not receive the associated health insurance benefits.
* I will be responsible for all of my health related expenses and neither ISU, nor the ISU Student and Scholar Health Insurance Plan, will be responsible for my health related, medical or dental expenses.

**I CERTIFY THAT** **THE ABOVE INFORMATION IS TRUE AND CORRECT AND REQUEST NOT TO PARTICIPATE IN THE ISU STUDENT AND SCHOLAR HEALTH INSURANCE PLAN.**

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Your Signature Date Signed

**Submit waiver form and supporting documentation to:**

Iowa State University, Benefits Office

3810 Beardshear Hall, 515 Morrill Road Ames, IA 50011-2103

Email: [isusship@iastate.edu](mailto:isusship@iastate.edu) Fax: (515) 294-8226 Phone: (515) 294-4800

*Office Use Only*

Waiver Approved \_\_\_\_\_\_\_\_ Denied \_\_\_\_\_\_\_\_\_\_ Effective Date \_\_\_\_\_\_\_\_\_\_\_

Email Sent BluesEnroll Updated \_\_\_\_\_\_\_\_ SSHIP SS \_\_\_\_\_\_\_\_

CyBox SS U-Bill Credit Payroll Credit

Notes

SSHIP-Waiver