



Southern Methodist University requires that all full-time International University students maintain health insurance coverage.

1. The insurance premium will be waived for international students sponsored by the United States Government, or a foreign government recognized by the United States of America. Waivers will be based on the government or organization guaranteeing payment of all health care expenses including medical evacuation and repatriation. Documentation including a copy of the U.S. health insurance policy, certificate and Insurance ID card, or guarantee by a foreign government must be presented to the Memorial Health center prior to January 23, 2012 to be considered for Spring 2012. If not received prior to this date, the semi-annual premium of \$759.00 will be charged to your SMU account and you will automatically be enrolled in the Student Health Insurance Plan.
2. The insurance premium will be waived for students who provide documentation of comparable U.S. health insurance coverage by a U.S. employer, including international medical evacuation and repatriation, documentation including a copy of the health insurance policy or certificate and Insurance ID card, must be presented to the Memorial Health center prior to January 23, 2012 to be considered for Spring 2012. If not received prior to this date the semi-annual premium of \$759.00 will be charged to your SMU account and you will automatically be enrolled in the Student Health Insurance Plan.

Please Print:

Student's Name	First	Middle Initial	Last
Mailing Address	Street or P.O. Box	City	State Zip Code
Cell Phone	() —	Home Phone	() —
SMU E-mail Address	Birthdate	____ / ____ / ____	Student ID #

Indicate below the type of insurance you have and attach the necessary documents in order for your waiver form to be considered. **This waiver form will not be accepted for consideration without all necessary documents attached.**

TYPE OF INSURANCE: (CHECK ONE)

SPONSORSHIP THROUGH AN EMBASSY (EXAMPLE: Saudi Cultural Mission, Kuwaiti Embassy, etc.)

Name of Insurance Company	
Name of Policyholder	
Group Number	
Subscriber/Member ID Number	
Birth date of policyholder	
Necessary Documents	<ul style="list-style-type: none"> — Front and back copy of insurance card with your name or a Certificate of Coverage showing effective dates of policy. — Documentation of medical evacuation and repatriation coverage.

ATTENDING ON J-1 OR H-1 VISA

Necessary Documents	<ul style="list-style-type: none"> — Certificate of Coverage showing effective dates of policy — Birth date of policyholder
----------------------------	---

COVERAGE PROVIDED BY OTHER EMPLOYER (EXAMPLE: You, your spouse or a parent has US insurance provided by a US Employer)

Name of medical insurance policyholder	
Your relationship to the policyholder	
Birth date of policyholder	
Name of company for whom policyholder works	
Name of Insurance Company	
Subscriber/Member ID Number	
Group Number	
Necessary Documents	<ul style="list-style-type: none"> — Front and back copy of insurance card with your name or Certificate of Coverage showing effective dates of policy. — Documentation of medical evacuation and repatriation coverage.



Southern Methodist University

2012 - SPRING
INTERNATIONAL WAIVER

I request a waiver of participation in the University Student Health Insurance Plan. I acknowledge that I am legally responsible for any and all medical expenses during my enrollment at Southern Methodist University and that Southern Methodist University will not be responsible for any medical expenses I may incur. By signing this form, I attest that the information provided about my insurance coverage is true and correct. I also understand that I must maintain insurance coverage throughout the entire term for which I have been granted a waiver. If I fail to maintain the insurance coverage presented with this form, I understand that I may lose my ability to be granted a waiver in the future.

I understand this request is subject to Southern Methodist University approval. If this request is denied or I fail to maintain my approved coverage, I understand that I may be subject to automatic billing of the semi-annual premium for participation in the University Student Health Insurance Plan for the term for which I have applied for a waiver.

Student Signature

Date

PLEASE NOTE: Information contained in this waiver is kept confidential and is used only for its intended purpose.

Forward the completed form with supporting documentation attached to:

Southern Methodist University
Memorial Health Center
Attention: Krista Pruitt
P.O. Box 750195
Dallas, TX 75275-0195

Fax: (214) 768-2151
Email: studenthealthinsurance@smu.edu

Note: If waiver is approved, the waiver information will be entered administratively in Access.SMU and the insurance premium will be waived. If the waiver is not approved, the student will be notified via the student's SMU student email account from SMU Health Insurance or Krista Pruitt.

Office Use Only:

Waiver requested is: Approved Denied Date: ___/___/___ Initials _____

Reason for Denied: _____