

**INDIANA UNIVERSITY SOUTH BEND INTERNATIONAL STUDENT  
HEALTH INSURANCE WAIVER FORM**

**Section I: Student Information**

**Student Name: Last (Family) Name:** \_\_\_\_\_ **First(Given) Name:** \_\_\_\_\_

**Student ID Number:** 000 \_\_\_\_\_ **Visa Type:** \_\_\_\_\_ **Telephone:** (\_\_\_\_)-\_\_\_\_-\_\_\_\_

**Student U.S. Street Address:** \_\_\_\_\_

**Street Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Postal Code:** \_\_\_\_\_

**Student Signature:** \_\_\_\_\_

*A copy of your insurance card and insurance policy must be attached to this form.*

*The Health Insurance waiver is not valid without copies of insurance card, insurance policy and effective dates.*

**Section II: Insurance Information**

**Name of Insurance Company:** \_\_\_\_\_

**Policy Number:** \_\_\_\_\_ **Country:** \_\_\_\_\_

**Effective Date:** \_\_\_\_\_ **Expiration Date:** \_\_\_\_\_

**Coverage Requirements:**

**Your Company's Benefits:**

\$50,000.00 for each sickness or illness .....

**Maternity Benefits: same as sickness;**

**Pregnancy childbirth, and complications.....**

\$50,000.00 for each accident or injury .....

\$10, 000.00 medical evacuation to home country .....

\$7,500.00 repatriation of remains to home country .....

**Deductible (or excess fee) not more than \$500.00**

**Per sickness or injury (per person).....**

**\$500,000.00 Lifetime policy Maximum (recommended)**

**\*\*Benefits must be covered to give amounts in U.S. Dollars**

**\*\*Exclusions and limitation must be more than comparable**

**\*\*Final decisions and approvals are made by Office of International Student Services**

**Please return completed for to:**

Telephone: +1 574 520 4419

Fax: +1 574 520 4590

[oiiss@iusb.edu](mailto:oiiss@iusb.edu)

**Office of International Student Services,**

A166X Indiana University South Bend

1700 Mishawaka Ave.

P.O. Box Box 7111

South Bend, IN 46634-7111

**Office Use Only:**

**Date Received:**

**Insurance Waived till:**

**Initials:**

**Date entered in BEX:**