USA Jag ID#: _____ E-Mail Address: _____
Name: _____
Street Address: _____
City, State, Zip Code: _____Telephone: _____

I have adequate health insurance coverage and request a waiver form the following semester(s):
__ Fall Semester __ Spring Semester __ Summer Semester

, understand that until the USA receives verification of coverage, I must be enrolled in the USA Student Health plan and pay all relevant premiums for the period of time core will be
WUSÁ_R P S O \ Z L W K W K H V H
O O U H V X O W S D Q W L F L S D Q L F R Q L Q W L R Q R W X G \ S U R J U D P

Student Signature: _____ Date: _____ S D U V

ddress: _____
Sponsor or Policy Holder Name: _____
Policy # _____ Group # _____ Coverage Dates:_____

Please verify MINIMUM STANDARDS by checking the appropriate box relative to the coverage provided. ALL of the following criteria MUST be met for the plan to be approved. Please check as appropriate (YES - coverage is provided, NO - coverage NOT provided):

B B < H V B B 1 R 7 K L V S R O L F \ S U R Y L G H V E R W K H P H U J H Q F \ D Q G Q R Q H P H U J H Q F \ K H D O W K F D U
O H D V W S H U D F F L G H Q W R U L O O Q H V V
__Yes __No A deductible no greater than $500 per accident or illness.
__Yes __No Coverage for repatriation of remains is equal to or greater than $25,000.
__Yes__No Medical evacuation coverage is equal to or greater than $50,000.
__Yes __No The claims administrator is based in the United States and has a US telephone number, address for Submission of claims. *Students will be responsible for submitting their own claims.
__Yes _