Office of Admissions
Health Insurance Waiver Form
Phone # 281-283-2500
Fax # 281-283-2522

Name _____ _____
Family (Last) Name Given (First) Name
Student ID #_____
Email Address _____
Telephone Number _____
Which semester (s) are you seeking waiver _____

I hereby certify that I understand participation in the UH System Student Insurance Program is mandatory, with exception granted only if eligible under one of the specific situations listed below. I acknowledge that I have provided written proof of eligibility for such exception as required on the Health Insurance Waiver Information Sheet.

Pursuant to the foregoing, I further certify that I am eligible for a Student Insurance Plan Fee Waiver for the specific reason checked below and that I voluntarily request the waiver. I further certify that I currently have health insurance which covers me for a minimum of $50,000 in health benefits, $10,000 Medical Evacuation and $7,500 Repatriation benefits for a period beginning the first day of class until the first day of class of the following semester. In addition to the preceding coverage, policies must meet standards comparable to UHCL Student Health Insurance. If my coverage does not provide it, I must purchase a policy to cover medical evacuation/repatriation which is available from the UH System Insurance Contractor for an annual fee of $31.00. This fee will be charged to my account if proof of medical evacuation/repatriation is not submitted by the deadline. ***The deadline to submit this form along with supporting documents for the Summer 2009 term is Monday, June 15, 2009 by 5 PM.***

I release and hold the University of Houston System harmless for any liability as a result of the University granting me a waiver from the Student Insurance policy.

☐ I am covered under a health insurance plan of my Employer or my spouse's employer.

_____ _____
Name of Employer (if applicable) Phone Number of Employer HR

_____ _____
Spouse's Name (if applicable) Insurance Company Name

☐ I am covered under a private policy.

☐ I am covered under a government or sponsored insurance.

_____
Student Signature/Date

☐ Approved ☐ Denied

_____
University Representative Signature/Date