

THE UNIVERSITY OF TEXAS AT DALLAS
Student Health Insurance Office

With few exceptions, you are entitled on your request to be informed about the information UT Dallas collects about you. Under Sections 552.021 and 552.023 of the Texas Government Code, you are entitled to receive and review the information. Under Section 559.004 of the Texas Government Code, you are entitled to have UT Dallas correct information about you that is held by us and is incorrect. Be assured that your UT Dallas records are protected from unauthorized disclosure by federal law.

Your UT Dallas ID is being requested because it is a unique identification number which is maintained for the purpose of verifying student identification.

SHI Waiver Request

Student Name: _____ Date of Birth: _____
(Family Name) (Given Name)

UT Dallas E-mail: _____ Visa type: _____

Semester Period for which waiver is requested: Fall 2009 Spring 2010 Summer 2010

In support of my request for a waiver from the requirement that I enroll in the Student Health Insurance Plan, I am currently covered under the following United States approved health insurance policy that meets or exceeds the following requirements:

- Yes No Coverage dates (**Check all that apply**):
- Fall 2009 (8/20/09 – 1/10/10)
 - Spring 2010 (1/11/10 – 5/25/10)
 - Summer 2010 (5/26/10 – 8/20/10)
- Yes No \$50,000 or more medical benefits for each illness or injury.
- Yes No A deductible not to exceed \$500 per accident or illness.
- Yes No Minimum of \$7,500 for repatriation of remains benefit.
- Yes No Minimum of \$10,000 for medical evacuation benefit.
- Yes No Policy plan meets federal solvency guidelines.

In addition, I am providing the following type of documentation to verify **(1) my coverage meets or exceeds the required minimums listed above** and **(2) the coverage will remain in effect during the period for which the waiver is requested**:

- A letter, or a copy of insurance policy pages(s) on insurance company letterhead, written in English, that:
- Identifies me as a covered individual
 - Provides the dates of my coverage
 - Clearly indicates that the coverage meets or exceeds the minimum requirements, including coverage amounts in U.S. dollars.

PLEASE HIGHLIGHT, CIRCLE, OR UNDERLINE THE REQUESTED INFORMATION ON YOUR INSURANCE DOCUMENTATION.

I certify that my current health insurance coverage meets or exceeds the above-listed minimum coverage. I understand that the sole purpose of UT Dallas staffs review of this information is to determine if I qualify for a waiver of enrollment in the Student Health Insurance Plan. I certify that **my health insurance coverage is in effect and will remain in effect for the entire UT Dallas Student Health Insurance coverage period for the semester for which I am requesting this waiver**. I understand that it is my sole responsibility to maintain the minimum coverage required by applicable federal regulations. The review by UT Dallas staff does not constitute a determination as to the adequacy of this coverage for any purpose. I certify that I am legally responsible for my own medical expenses and that UT Dallas is not responsible for such expenses.

Student Signature: _____ Date: _____

OFFICE USE ONLY

SID#: _____

Insurance Waiver Codes

2098 = Fall
2102 = Spring
2105 = Summer

Repatriation / Evacuation

R/E Company: _____

Date of Expiration: _____

Repatriation / Evacuation Codes

2098 = Fall
2102 = Spring
2105 = Summer

Complete in PeopleSoft

ISSO Approval Signature / Date: _____