☐ Domestic Student
(Please check box and complete front page only)

☐ International Student
(Please check box and complete front and back of this form)

**GRAMBLING STATE UNIVERSITY**
**FOSTER-JOHNSON HEALTH CENTER**
403 Main Street, Box 4251
Grambling, LA 71245
Phone: (318) 274-2351/Fax: (318) 274-2481
Web: www.gram.edu

# STUDENT INSURANCE WAIVER REQUEST

**Term: _____ Fall Semester _____Spring Semester _____Summer Session I _____Summer Session II**
**Year Year Year Year**

All students are required to have health insurance coverage (Domestic - Accident only/International - Sickness and Accident) throughout the school year as a condition of enrollment. These students will be enrolled in and billed for the College-endorsed Student Insurance Plan in four installments (fall, spring, summer I, summer II) **UNLESS proof of other adequate health insurance is furnished**. Students must submit a waiver request by the posted deadline each academic semester or session and the waiver request must be approved to avoid being enrolled in the Student Insurance Plan. It is the student's responsibility to verify whether or not the charge has been billed to your student account. If there is a billing error, you should contact the Student Accounts Coordinator immediately at (318) 274-2087.

Submit the insurance waiver form, with a copy of proof of insurance and proof from your insurance carrier that coverage is accepted at the local hospital (NLMC) and area clinic (Green Clinic), to Foster-Johnson Health Center for approval in **person only**. Forms sent by fax or mail will not be accepted. Keep a copy for your record.

## Student Information

Student G Number: _____

Last Name: _____ First Name: _____ MI: _____

Birth Date: _____ (Ex: mm/dd/yyyy) Gender: ☐ Female ☐ Male

Mailing Address: _____

Mailing City: _____ Mailing State: _____ Mailing Zip: _____

Email: _____ Telephone: _____

## Insurance Information

Insurance Company Name: _____

Insurance Company Phone (U.S.): _____

Policy Holder Name: _____

Policy Holder Birth Date: _____

Policy Number: _____

Group Number: _____

**Foster-Johnson Health Center Stamp**

**Place stamp here**

Please answer the following questions to determine if your current coverage exempts you from purchasing the College's recommended insurance coverage.

1. ☐ Yes ☐ No Does your insurance provide coverage for the entire academic term?

Print

**Acknowledgement:**

By signing, the student acknowledges the following: 1) He/She has read the College's Insurance Requirement policy found on the Student Health Center website; 2) He/She has adequate health insurance coverage in accordance with said policy and therefore elects to waive the College's Student Insurance Plan for the selected academic period; 3) The Student's current insurance coverage is effective for the entire selected academic period; and 4) That the information provided herein is true and correct to the best of his/her knowledge.

_____ _____ _____ _____
**Student's Signature** **Date** **Parent or Legal Guardian Signature, if a minor** **Date**


(continued on back)

Last Name: _____ First Name: _____ MI: _____

Student G Number: _____ Birth Date: _____ (Ex: mm/dd/yyyy) My country of citizenship: _____

I attend GSU on a: ◯ F-1 Visa ◯ J-1 Visa I am: ◯ Undergraduate Student ◯ Graduate Student

Note: J-1 visa holders must have health insurance for the entire period of stay (not simply enrollment at GSU) and must also cover all family members under this visa.

**I qualify for the waiver under the following category:**

◯ I am sponsored by my country's Embassy. (Attach a copy of your Letter of Sponsorship)
◯ I am covered by insurance other than the GSU student health insurance plan.

| **I acknowledge that by submitting the health insurance waiver form, I am waiving out of the GSU student health insurance plan and certify that:** (Please initial after each statement) | **Initial** |
|---|---|
| 1. I am currently enrolled in a health insurance plan that will remain in effect during my enrollment at GSU. | |
| 2. I have communicated with my health insurance carrier and determined all benefits meet the minimum GSU health insurance and immigration requirements. It will also adequately cover me during transit and during my stay in the U.S. | |
| 3. I understand that if I am involuntarily terminated from my health insurance, I will be responsible for obtaining another health insurance plan. | |
| 4. I will be solely responsible for all medical expenses. GSU will not be held responsible for any medical expenses that I incur during my enrollment or during my stay in the U.S. | |
| 5. I will notify GSU if my insurance coverage changes or if it ends during my enrollment. | |
| 6. I will promptly pay expenses incurred through my health care provider that are not covered by my policy or any part of the deductible amount. | |
| 7. I understand that I must submit the international student waiver by the deadlines posted on Foster-Johnson Health Center webpage. | |

With your company's health insurance Summary of Coverage, use this worksheet to compare your health insurance plan to the GSU minimum health insurance requirements. Please check the box that applies to your coverage.

| | **GSU Minimum Plan Coverage Requirement** | **Yes** | **No** |
|---|---|---|---|
| Coverage | Coverage valid in Louisiana for outpatient care, hospitalization, emergency room accidents, medical and surgery needs to be provided. | | |
| Medical Benefits | Comprehensive medical coverage of at least $500,000 per accident or illness. | | |
| Repatriation of Remains | Coverage for repatriation - Actual Cost. | | |
| Medical Evaluation | Expenses associated with the medical evacuation to his or her home country included – Actual Cost. | | |
| Deductible | Not to exceed $200.00 per accident or illness. | | |
| Medical Coverage | At least 80% coverage for each accident or illness. | | |
| Behavioral Health | Plan includes behavioral health coverage. | | |

I understand that information provided, herein, is confidential and will be used for the sole purpose of documenting my decision to waive the GSU student health insurance. Furthermore, this information will not be made available to any third party outside of GSU.

I understand that if I check no to minimum requirements for medical benefits, deductible, medical coverage, and behavioral health, I am still eligible to waive the university sponsored international insurance plan. I further understand that it will be my responsibility to cover any medical charges incurred during my stay abroad, if my present insurance carrier denies charges.

_____ _____ _____ _____

**Student's Signature** **Date** **Parent or Legal Guardian Signature, if a minor** **Date**

**Print**