

## HEALTH INSURANCE WAIVER FORM

All international students in F-1 status are required to have health insurance while in F-1 status at UCLA Extension. Students who request a waiver of the mandatory insurance must demonstrate that they have comparable insurance coverage each quarter by submitting additional documentation showing proof of coverage (ie copy of insurance card, confirmation letter from insurance provider, etc). To ensure full medical coverage, the health insurance should cover dates starting from the first day of arrival in the U.S. and include breaks and gaps in between quarters. The start and end dates of each quarter can be found on the Academic Calendar: <https://www.uclaextension.edu/calendar>

Family Name: \_\_\_\_\_ First Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ UCLA Extension Student ID: \_\_\_\_\_  
Certificate program to study at UCLA Extension: \_\_\_\_\_

Insurance Information – Reason for waiver request  
Please check **all that apply**:

- I have health insurance coverage from a separate U.S.-based insurance company.
- I am included in my spouse/parent's health insurance coverage.
- I have health insurance coverage from my (check one):  sponsoring agency  employer  government
- I have private health insurance coverage from my home country.
- Other: \_\_\_\_\_

I confirm that the alternative insurance policy I have selected meets the following coverage requirements:

1. *Must be written in English, including your name and dates of coverage.*
2. *Provides comparable coverage in the amount of at least \$500,000 annually.*
3. *Has a deductible or out of pocket expense of \$250 or less per condition.*
4. *Has coverage for pre-existing conditions.*
5. *Provides at least \$25,000 for repatriation of remains to the home country.*
6. *Provides at least \$50,000 for medical evacuation to the home country if medically ordered.*
7. *Outpatient/Behavioral Health and Substance Abuse is covered as any other illness.*

My coverage is from (MM/DD/YYYY) \_\_\_\_\_ until (MM/DD/YYYY) \_\_\_\_\_

**I am responsible for renewing, cancelling, settling payment, and following up with all matters related to the insurance company. The university has no liability on any medical expenses I incur and/or in excess of my insurance coverage.**

Print name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_