



Health Insurance Verification Form

Family Name	First Name	Student ID Number
E- Mail Address		Date of Birth

PLEASE IDENTIFY THE HEALTH INSURANCE WHICH APPLIES TO YOU:

- I have health insurance coverage because I am sponsored by either U.S. Government, through my home country (Embassy), or through the U.N. **Attach copy of your sponsorship letter indicating Health Insurance Coverage and a copy of insurance card.**
- I have health insurance through a parent’s work, spouse’s work or my work. (If this is a non US policy you must attach verification that health care expenses will be covered in the US and this coverage must meet CSU requirements below) **Attach Copy of policy and copy of insurance card**
- I am presently insured by another carrier and am receiving benefits due to an ongoing illness and would lose coverage if I switched to CSU Health coverage. (Must provide proof that you need to stay with this company and this coverage must meet CSU requirements below) **Attach copy of Policy and copy of insurance card**

Check yes or no by each to verify you coverage meets CSU Requirements

<input type="checkbox"/> yes <input type="checkbox"/> no	Medical Benefits of at least 80% of first \$50,000 of covered expenses
<input type="checkbox"/> yes <input type="checkbox"/> no	Repatriation of Remain in the amount of at least \$10,000
<input type="checkbox"/> yes <input type="checkbox"/> no	Expenses for Medical Evacuation to home Country at least \$15,000
<input type="checkbox"/> yes <input type="checkbox"/> no	Deductible of no greater than \$75 per accident or illness
<input type="checkbox"/> yes <input type="checkbox"/> no	Co-payment or coinsurance not to exceed 20% of covered expenses
<input type="checkbox"/> yes <input type="checkbox"/> no	Company who provides the coverage has required rating

- Bill my student account for Student Health Insurance

YOU MUST READ AND SIGN THIS STATEMENT

I certify that the above information is accurate and complete. I request the Student insurance fee be waived on the basis that I have and will maintain comparable insurance coverage. I understand that if later I lose coverage and want to be enrolled in the Student Health Plan I will have to notify CISP in writing. I also understand that if my insurance coverage changes or expires I may be enrolled in Cleveland State University’s Student Health Plan unless I provide proof of new insurance to CISP. I further acknowledge that a request to waive student health insurance must be submitted every August I wish to waive. **Health Insurance is a requirement as stated on your I-20 and of the University. Not adhering to this policy can put your status in jeopardy.**

Signature _____ Year Waiving _____ Date _____

Note: **If this form is not returned, returned incomplete, or returned after the deadline above, automatic billing of the health insurance fee may not be waived.** CISP cannot be responsible for errors in fax transmission. Should a question arise regarding your submission of a waiver request, a dated fax and fax transmittal form is the only acceptable proof that you submitted your waiver prior to the deadline.

FOR MORE INFORMATION CALL 216-687-3910

Cleveland State University USE ONLY

Status of Waiver **Approved** _____

Pending (reason) _____

Denied (reason) _____