UC International Programs

UNIVERSITY OF CINCINNATI MEDICAL INSURANCE FOR PROGRAMS ABROAD

REQUIREMENTS & WAIVER REQUEST FORM

ALL UC Students participating in a University of Cincinnati – sanctioned or funded international travel program are required to purchase and maintain continuous insurance while abroad. It is the strong recommendation that students enroll in the comprehensive coverage the University has secured on your behalf. Students may waive the University of Cincinnati Medical Insurance for Programs Abroad Plan by filing the waiver form below, provided that:

- The student HAS coverage through another carrier that meets the minimum specifications stated below;
- AND that coverage will be in effect for the full duration of the student's program abroad.

If you have coverage that meets these requirements and you do not wish to sign up for the University insurance designed for programs abroad, you should have your insurance company representative complete the form below.

MANDATED MINIMUM COVERAGE LEVELS

The required minimum insurance levels are:

____ Basic Medical Coverage Abroad ($100,000 minimum)

____ Emergency Medical Evacuation ($250,000 minimum or 100% of evacuation costs)

____ Repatriation of Remains ($100,000 minimum or 100% of repatriation costs)

____ Security Evacuation (ex: military, political, personal threat, natural disaster) ($100,000 minimum or 100% of repatriation costs)

STUDENT AND PROGRAM INFORMATION

_____ ____/____/____ _____

Student's Last Name First Name M.I. Student's Date of Birth UC Student ID#

Program Location: _____ Program Dates: ____/____/____ ____/____/____

Departure Date Return Date

Student E-Mail: _____

COMPARABLE COVERAGE WAIVER REQUEST

(to be completed by insurance company representative)

I certify that _____ provides all of the above described coverage for the period:

(Name of Insurance Provider) from: ____/____/____ ____/____/____

(Departure Date) (Return Date)

Provider Representative: _____

(Print Name & Title)

Representative Signature: _____ Date: _____

Address: _____

(Street/Mail Address City State Zip Code)

Telephone: (____) _____ E-mail: _____

TO THE INSURANCE COMPANY REPRESENTATIVE: *Please Sign* I ATTEST TO THE FACT THAT THIS INSURANCE COVERAGE COVERS THE ABOVE LISTED MANDATED MINIMUM COVERAGE LEVELS, THAT THE COVERAGE WILL BE IN EFFECT FOR THE FULL DURATION OF THE PROGRAM ABROAD AND THAT THE INFORMATION CONTAINED ON THIS FORM IS CORRECT.

_____

(Signature of Insurance Provider)