



Hawai'i Pacific University International Student Health Insurance Waiver

Forms & Instructions

Hawai'i Pacific University requires all full-time international students to have health insurance as a condition of enrollment at the University. HPU strongly recommends that students purchase one of the HPU plans. However, under limited circumstances HPU may waive this requirement if a student provides adequate proof of coverage by completing the Health Insurance Waiver Request form. Due to the high cost of medical services, we still recommend purchasing one of the HPU plans to provide full coverage while in Hawaii.

Included in this international student health insurance waiver packet are:

Form A: Health Insurance Waiver Request

Form B: Health Insurance Worksheet

Form C: U.S. Employer Insurance Verification Worksheet

Please note that student athletes, whether International or U.S., are also required to comply with separate NCAA requirements. This form does not waive such NCAA requirements and international student-athletes may still be required to obtain insurance for sports.

To obtain a waiver, you must complete the following:

Step 1: Complete Form A and attach requested documents.

Step 2: Complete Form B or C if it applies to you.

Step 3: Return the forms and documents to the International Center by the third Friday of your enrollment term. Students who fail to return their forms will be required to purchase health insurance and complete the health insurance enrollment form. Failure to do so will result in a hold on your student account (for example, no transcripts can be obtained; no further course registration is possible).

Submit the completed forms to the International Center in person (1164 Bishop Street, Suite 1100), fax at +1-808-543-8065, or by mail to:

Hawai'i Pacific University
International Center
1164 Bishop Street, Suite 1100
Honolulu, Hawaii 96813 - U.S.A.

If you have further questions, contact us at +1 (808) 543-8088.



Hawai'i Pacific University Health Insurance Waiver Request Form A

Last Name	First Name	University Student ID # @
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My citizenship is: _____ I am: Undergraduate Student Graduate Student

I attend HPU on a: F-1 Visa J-1 Visa

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

I qualify for the waiver under the following category:

- I am covered by one of the following organizations with pre-approved coverage:** *Fulbright Scholars (USDOS); Embassy of Kuwait; Embassy of Qatar; Embassy of Oman; Royal Thai Embassy of Educational Affairs.*
 - Attach copy of your insurance card, health insurance policy, or written verification of coverage in English.
- I am covered by insurance other than those listed above.**
 - Complete Forms A & B and attach copy of your insurance card or health insurance policy in English.
- I am sponsored by my Embassy.**
 - Attach a copy of your letter of sponsorship and a copy of your insurance card or health insurance policy in English to Form A.
- I am covered as a U.S. based employee or as a dependant of a U.S. based employee.**
 - Attach a copy of the health insurance card or health insurance policy in English with Forms A & C.
 - Attach proof of enrollment in travel insurance that covers Repatriation of Remains and Emergency Evacuation (Form C) to your legal country of citizenship as it is not included in your employee health coverage.

I acknowledge that by submitting the health insurance waiver form, I am waiving out of the Hawai'i Pacific University student health insurance plans and certify that:

1. I am currently enrolled in a health insurance plan that will remain in effect during my enrollment at HPU.
2. I have communicated with my health insurance plan carrier and determined the benefits meet the minimum HPU health insurance requirements, meet immigration requirements and will adequately cover me during transit and during my stay in the U.S..
3. I understand that only if I am involuntarily terminated from my health insurance plan, I may be eligible to enroll in one of the HPU student health insurance plans only during open enrollment periods. Otherwise, I will be responsible for obtaining another health insurance plan.
4. I will be solely responsible for all medical expenses. Hawai'i Pacific University 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 the International Center if my insurance coverage changes or if it ends during the semester.
6. I will promptly pay expenses incurred through my healthcare provider that are not covered by my policy or are part of the deductible amount.
7. I must renew my full health insurance waiver application each term or at the end of my last waiver period, whichever comes first.

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

I am also granting Hawai'i Pacific University and its agents the permission to verify this information through an auditing process. I understand that the waiver approval or denial decisions are made at the sole discretion of the International Center and HPU. If it is determined that the information provided on this form is invalid and/or I do not submit my waiver by the deadline, **I understand that I will be required to purchase one of the HPU's health insurance plans for the term and for future subsequent terms. In addition, a hold may be placed on my HPU student account (for example, no transcripts can be obtained; no further course registration is possible).**

Signature of Student (must be at least 21 yrs of age)

Date

Signature of Parent/Guardian/Sponsor if Under 21 yrs. of age

Date

Office Use Only						
Date Received/Initials:	Waiver approved Yes / No	By:	Waiver begin date:	Waiver end date:	GOAMEDI By: _____ Date: _____	SOAHOLD By: _____ Date: _____
Special notes:						



Hawai'i Pacific University

Health Insurance Worksheet

Form B

Last Name	First Name	University Student ID # @	Email Address
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With your company's Summary of Coverage, use this worksheet to compare your health insurance plan to the HPU minimum health insurance requirements. Please check the box that applies to your coverage.

	HPU Minimum Plan Requirements	Student's Coverage
Coverage Dates	Valid policy coverage dates for the effective semester(s). List semester(s)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Coverage	Coverage valid in Hawaii for outpatient care, hospitalization, emergency room, accidents, medical and surgery needs to be provided.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Medical Benefits	Minimum \$100,000 USD coverage; medical benefits of at least \$50,000 USD per accident or illness.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Repatriation of Remains	At least \$7,500 USD coverage for repatriation.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Medical Evacuation	Expenses associated with the medical evacuation to his or her home country included -- \$10,000 USD minimum.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Deductible	Not to exceed \$500 USD per accident or illness.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Medical Coverage	At least 75% coverage for each accident or illness.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Reimbursement	Health plan has a non-reimbursement policy. This means that all medical bills must be paid DIRECTLY by the insurance company to the medical provider, including all medical providers in Hawaii.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Miscellaneous	The Plan must either be: 1. Underwritten by an insurance corporation with an A.M.Best rating of "A-" or above, an Insurance Solvency International, Ltd. (ISI) rating of "A-I" or above, a Standard and Poor's Claims Paying Ability rating of "A-" or above, or a Weiss Research, Inc. rating of "B+" or above. 2. Be backed by the full faith and credit of the government of his or her home country. [22 CFR 62.14]	<input type="checkbox"/> Yes <input type="checkbox"/> No

Waiver Policy Information

Policy Holder Name: _____

Relationship to student: _____

Effective Date: _____ **Termination Date** _____

Insurance Company Name: _____

Member ID or Subscriber No: _____

Address of Insurance Company: _____

Phone Number _____

(Include full Country Code Nos): _____

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Hawai'i Pacific University

U.S. Employer Insurance Verification

Form C

Last Name	First Name	University Student ID # @
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STUDENT PORTION

I understand I must provide this form EACH TERM I am enrolled for credits at Hawai'i Pacific University. I must renew my full health insurance waiver application each term or at the end of my last waiver period, whichever comes first. Otherwise, a hold will be placed on my HPU student account (e.g. no transcripts can be obtained; no further course registration is possible).

Student Signature: _____ Date: _____

EMPLOYER PORTION

Please accept this as verification that the above listed student is currently provided with health benefits through the insurance plan, which meets the requirements listed in Form B. These benefits are expected to remain in effect throughout their employment with our company.

Name of primary insured: _____

Insurance ID number of primary insured: _____

Insurance company name: _____

This plan also:

DOES Provide coverage for Repatriation of Remains (\$7,500 minimum) and Emergency Evacuation (\$10,000 minimum) to the student's country of legal citizenship.

DOES NOT cover Repatriation of Remains and Emergency Evacuation to their country of origin. The student must purchase privately a separate travel insurance (of their choice) and submit it in combination with this form.

Supervisor/Human Resources Signature & Company Stamp: _____ Date: _____

Title: _____ Phone: _____

Office Use Only						
Date Received/Initials:	Waiver approved Yes / No	By:	Waiver begin date:	Waiver end date:	GOAMEDI	SOAHOLD
	Special notes:			By: _____	By: _____	
				Date: _____	Date: _____	

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