



## Hawai'i Pacific University International Student Health Insurance Waiver

### Forms & Instructions

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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: Waiver Comparison

Form C: 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.

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#### **To obtain a waiver, you must complete the following:**

**Step 1:** Contact your health insurance carrier to make sure your current medical insurance plan meets the HPU requirements detailed in Form B.

**Step 2:** Complete Forms A and B. Form C applies only to students who receive employer-based health insurance).

**Step 3:** Return the forms and documents to the International Center by the third Friday of your enrollment term. 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).

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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 #<br>@ |
|-----------|------------|------------------------------|

My citizenship is: \_\_\_\_\_

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

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 insurance card.
- I am covered by insurance other than those listed above.**
  - Either attach English summary of coverage from insurance carrier or Complete Form B.
- I am sponsored by my Embassy.**
  - Attach a copy of your letter of sponsorship and a copy of your insurance card 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 other proof of coverage along with Form 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, **I understand that I will be required to purchase one of the HPU student health insurance plans for that term and for future, subsequent terms. Otherwise, a hold will 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.

\_\_\_\_\_  
Date

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



# Hawai'i Pacific University

## Waiver Comparison

### Form B

|           |            |                              |
|-----------|------------|------------------------------|
| Last Name | First Name | University Student ID #<br>@ |
|-----------|------------|------------------------------|

With your company's Summary of Coverage, use this worksheet to compare your health insurance plan to the HPU minimum health insurance requirements.

|                         | HPU Minimum Plan Requirements                                                                                                                                                                                                                                                                                                                                                                                                     | Student's Coverage |
|-------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------|
| Coverage Dates          | Valid policy coverage dates for the effective semester(s).                                                                                                                                                                                                                                                                                                                                                                        |                    |
| Coverage                | Coverage valid in Hawaii for outpatient care, hospitalization, emergency room, accidents, medical and surgery needs to be provided.                                                                                                                                                                                                                                                                                               |                    |
| Medical Benefits        | Minimum \$100,000 USD coverage; medical benefits of at least \$50,000 USD per accident or illness.                                                                                                                                                                                                                                                                                                                                |                    |
| Repatriation of Remains | At least \$7,500 USD coverage for repatriation.                                                                                                                                                                                                                                                                                                                                                                                   |                    |
| Medical Evacuation      | Expenses associated with the medical evacuation to his or her home country included -- \$10,000 USD minimum.                                                                                                                                                                                                                                                                                                                      |                    |
| Deductible              | Not to exceed \$500 USD per accident or illness.                                                                                                                                                                                                                                                                                                                                                                                  |                    |
| Medical Coverage        | At least 75% coverage for each accident or illness.                                                                                                                                                                                                                                                                                                                                                                               |                    |
| 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.                                                                                                                                                                                                                                  |                    |
| Miscellaneous           | The Plan must either be:<br>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.<br><br>2. Be backed by the full faith and credit of the government of his or her home country. [22 CFR 62.14] |                    |

### 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): \_\_\_\_\_

*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.*



# Hawai'i Pacific University Employer Insurance Verification Form C

|           |            |                              |
|-----------|------------|------------------------------|
| Last Name | First Name | University Student ID #<br>@ |
|-----------|------------|------------------------------|

### 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 | By: | Waiver begin date: | Waiver end date: | <b>GOAMEDI</b> | <b>SOAHOLD</b> |
|                         | Yes / No        |     |                    |                  | By: _____      | By: _____      |
|                         | Special notes:  |     |                    |                  | Date: _____    | Date: _____    |

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