Western Oregon UNIVERSITY

International Health Insurance Waiver Form

International students enrolled in courses at WOU are required to have health and accident insurance coverage. The only exception is for students with government-sponsored medical insurance provided by their home government.

WOU partners with Gallagher to offer a health plan that meets immigration requirements. If you don't have government-sponsored insurance, you'll be automatically enrolled and charged for this international insurance plan each term.

TERM	Fall	Winter	Spring	Summer
DATES	Sept 1, 2025 - Jan 7, 2026	Jan 8 – Apr 1, 2026	Apr 2 – Jun 24, 2026	June 25 – Aug 31, 2026
RATE	$707.00	$461.00	$461.00	$373.00

For students on a qualified break (after completing 9 consecutive months of study), students:

- May request enrollment in the international insurance plan by contacting the OIED.
- Acknowledge the risk of remaining in the U.S. without insurance and accept full responsibility for any medical costs incurred during the uninsured period.

Waiver Information

- If you enroll in another international insurance plan, you may be eligible for a waiver each term. You are **required** to complete this form, provide proof of coverage showing the dates of coverage, and the coverage must meet specific requirements.

- If your plan meets all the requirements, the petition to waive the WOU international insurance plan will be approved and you'll receive a credit to your account for the current term. If the policy does not meet the requirements, the petition will be denied and your account will be charged for the WOU international insurance plan.

- Students are encouraged to ensure their policy meets all the requirements before buying an outside policy to prevent paying for two plans in the case that the waiver is not approved.

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To waive the WOU insurance plan, please complete this form.

Student Information

First Name _____ Last Name _____

Student V# _____ WOU Email _____

Local Address _____ City _____ State _____ Zip _____

Phone Number _____

I want to WAIVE participation in the Gallagher Student Health Insurance Plan for:

- ☐ Fall 20____
- ☐ Winter 20____
- ☐ Spring 20____
- ☐ Summer 20____

☐ I understand by waiving coverage, I am waiving coverage for the term selected above and will not be able to enroll at a later date unless I lose coverage under my current health insurance plan.

☐ I understand that I may not waive the Gallagher Student Health Insurance Plan unless I am covered by an insurance plan based in the United States* that is comparable to the plan offered by Western Oregon University. ***Plans based in a US Territory (Guam, Virgin Islands, Puerto Rico) <u>are not</u> comparable and cannot be used to waive the school's Student Medical Insurance Plan**.

☐ I acknowledge that by waiving the Gallagher Student Health Insurance Plan, I confirm that I am currently enrolled in a health insurance plan and will be continuously insured for the school year. I have reviewed both plans and have determined my current coverage to be comparable. I further acknowledge that by waiving the Gallagher Student Health Insurance Plan, I will be solely responsible for any medical expenses I may incur and that neither Western Oregon University nor Gallagher Student Health & Special Risk will be held responsible for any medical expenses.

☐ I further understand that by submitting this form, I am granting permission for Gallagher/Western Oregon University to audit this information for documentation purposes. If the information provided on this form is falsified, I understand that I will be enrolled in the Gallagher Student Health Insurance Plan and will be charged the full insurance premium.

Student Signature _____ **Date**_____

Benefit Requirements

Please check with your health insurance plan regarding the following before waiving coverage.

My current health insurance plan provides:

Yes	No	
☐	☐	Coverage for the entire term I am requesting to waive
☐	☐	Medical benefits of $100,000 per accident or illness
☐	☐	Repatriation of remains coverage amounting to $25,000
☐	☐	Expenses associated with the medical evacuation of the exchange visitor to his or her home country in the amount of $50,000
☐	☐	A deductible not exceeding $500 per accident or illness
☐	☐	Pre-existing condition waiting period as determined by current industry standards
☐	☐	Coverage available in the United States with a physical U.S. based office
☐	☐	Coverage for inpatient and outpatient hospitalization; access to local doctors, specialists, hospitals and other health care providers in emergency and non-emergency situations; coverage for lab work, diagnostic x-rays, physical therapy and chiropractic care, emergency room treatment, ambulance services, and prescription coverage.
☐	☐	Coverage for inpatient and outpatient mental health, substance abuse and counseling services.

If you have answered **NO** to any of the questions **STOP**, you are not qualified for a Waiver from the WOU International Insurance policy because your plan is not comparable.

If you have answered **YES** to all the questions above, you are eligible to waive enrollment in Gallagher Student Health Insurance plan.

Insurance Company Information

Name of Insurance Company _____

Is Company based in the U.S.? ☐Yes ☐No

Insurance Company Street Address/PO Box _____

Insurance Company City _____ State _____ Zip Code _____

Phone Number (800# Preferred) _____

Name of Policy Holder _____

Policy Holder ID# _____

Type of Insurance _____ Subscriber/Member ID# _____

Attach a copy of your health insurance plan which shows the coverage dates.