F-1 STUDENT HEALTH INSURANCE
STUDENT ACKNOWLEDGMENT & INSURANCE PROVIDER CERTIFICATION FORM

Last Name, First Name

Student ID#

Birthdate (mm/dd/yyyy)

Names of all F-2 Dependents Covered under this plan:

I acknowledge that University of Hawaii (UH) policy requires international students to provide evidence of comprehensive health insurance while I am enrolled at the University. I acknowledge that it is my responsibility to choose my own health insurance provider and to obtain the provider’s certification that the plan meets specific minimum coverage requirements. I further acknowledge my responsibility to maintain insurance coverage and to submit this form at each and every renewal or change of provider. Further, I understand that University required minimum coverage levels may change each year and that I am responsible for updating my insurance in keeping with stated requirements.

I certify that I am covered by comprehensive health insurance as described below. I promise to remain covered by comprehensive health insurance throughout the time I am enrolled at the University. I acknowledge and agree that the University is not responsible for my health insurance or medical expenses. If I have dependents, all of my certifications, promises, acknowledgments, and agreements extend to my dependents as well as myself.

Student Signature
Date

The section below must be completed by the health insurance company:

Name(s) of insured individual(s):

Insurance Provider:

Policy Number/Plan Type: ___________________________ Dates*: ___________________________ to ___________________________

*While enrolled at UH, you are required to have health insurance. The plan/policy must meet ALL of the following minimum coverage requirements (all amounts are in USD). Vision/dental coverage is not required.

Agent: initial each line below to verify all coverage requirements.

_____ *Comprehensive medical coverage = at least $100,000 US per accident/illness
_____ *Inpatient/Outpatient medical (including mental health) coverage at no less than 75% usual/customary charge (UCC)
_____ *Repatriation coverage = at least $25,000 US
_____ *Medical evacuation coverage to home country = at least $50,000 US
_____ *No more than $500 US deductible per accident or illness
_____ *Waiting period for pre-existing conditions no longer than 6 months

I certify that the minimum coverage requirements stated above are provided by this policy/plan. I am qualified to make this determination as an authorized agent/employee of the above insurance provider.

Print Name
Contact Information (email and/or phone number)

Signature
Title
Date

For UHM use only: Approved for Term: _____________ Until (date): _____________ By: __________ Date: __________
Disapproved for: Term: _______ For: Insufficient coverage: _____ Insufficient documentation: _____ By: _____ Date: _______
INSTRUCTIONS:
F-1 Student Health Insurance
Student Acknowledgment & Insurance Provider Certification Form

I. All UH Manoa F-1 students must complete & submit this form
   Go to www.hawaii.edu/shs/international & click on “How to Receive Insurance Clearance” to see what additional documents are required
A. Students who are on the UH Student Plan or the UH Employer Plan (EUTF) need to complete & sign the top portion of the form and submit that to the student insurance office along with your other required documents.
B. Students who are on any other insurance plan need to have the entire form completed & signed before submitting.

II. Top Portion of the Form (see sample “section A”)
A. Student to complete all the areas that are highlighted in yellow and sign & date the form.
B. Read the statement of acknowledgement carefully. The statement indicates that while you are enrolled at the University of Hawai‘i (UH), it is your responsibility to maintain health insurance coverage for yourself & that your plan meet UH’s standards. It is also your responsibility to update your plan if the standards change, and to submit this form each time you renew your policy or change providers or plans.

III. Bottom Portion of the Form (see sample “section B”)
This section does not need to be completed if you are on the UH Student Plan or the UH Employer Plan (EUTF).
A. Your insurance company must complete all the areas that are highlighted in yellow and sign & date the form.
   IMPORTANT: Your insurance company must initial each of the minimum coverage requirements.
B. University Minimum Coverage Requirements
   Go to www.hawaii.edu/shs/international & click on “Health Insurance Requirements” for more information
   1. While enrolled at UH, you are required to have coverage that meet's UH's minimum requirements.
   2. Comprehensive medical coverage = at least $100,000 US per accident/illness
      Your plan must provide medical benefits (doctor visits, hospital, surgery, laboratory tests, x-rays, etc.) of at least $100,000 US (American dollars) for each accident or illness.
   3. Inpatient/Outpatient medical (including mental health) coverage at no less than 75% usual/customary charge (UCC)
      Your plan must pay at least 75% of covered medical expenses (including mental health coverage) for both inpatient (stay at an inpatient facility/hospital) and outpatient (doctor's office, outpatient department of a hospital or ambulatory surgery center) services.
   4. Repatriation coverage = at least $25,000 US
      If you should die in the U.S., your plan must provide at least $25,000 US (American dollars) to send your body/remains back to your home country.
   5. Medical evacuation coverage to home country = at least $50,000 US
      If, due to a serious illness or injury, your doctor recommends that you return to your home country for treatment and/or recovery, your plan must provide up to $50,000 US (American dollars) for you to return home.
   6. No more than $500 US deductible per accident or illness
      Your plan deductible cannot exceed $500 US (American dollars) for each accident or illness. Most insurance plans require you to pay for part of your health expenses (this is called the deductible) before they will start to pay for any covered services. Some plans also have deductibles per year instead of per accident or illness. As long as your plan does not exceed the $500 US deductible (per accident/illness or per year) then this requirement will be fulfilled.
   7. Waiting period for pre-existing conditions no longer than 6 months
      Your plan cannot exclude coverage for any pre-existing conditions longer than 6 months. Some plans exclude pre-existing conditions while some plans might have a waiting period for pre-existing conditions. A waiting period means that your plan will not cover any pre-existing conditions for a certain amount of time; this waiting period can range from 6 to 18 months. As long as your plan has either no exclusions for pre-existing conditions or a waiting period of 6 months or less, then this requirement will be fulfilled.

IV. Where to Submit this Form
A. This form AND any other insurance documentation (if applicable) may be faxed, mailed, e-mailed, or personally delivered to the Student Health Insurance Office:
   University of Hawai‘i Manoa
   2600 Campus Road, QLCSS #313D
   Honolulu, HI 96822
   Email: shio@hawaii.edu
   Fax: (808) 956-6371
F-1 STUDENT HEALTH INSURANCE
STUDENT ACKNOWLEDGMENT & INSURANCE PROVIDER CERTIFICATION FORM

A. Doe, Jane
   Last Name, First Name
   2345-6789
   Student ID#
   12/24/2000
   Birthdate (mm/dd/yyyy)

Names of all F-2 Dependents Covered under this plan: ____________________________

I acknowledge that University of Hawaii policy requires international students to provide evidence of comprehensive health insurance while I am enrolled at the University. I acknowledge that it is my responsibility to choose my own health insurance provider and to obtain the provider’s certification that their plan meets the minimum coverage requirements. I further acknowledge my responsibility to maintain insurance coverage. I agree to submit this form at each and every renewal or change of provider. Further, I understand that University of Hawaii minimum coverage levels may change each year and that I am responsible for updating my insurance in compliance with these requirements.

I certify that I am covered by comprehensive health insurance as described below. I promise to remain covered by comprehensive health insurance through the date I am enrolled at the University. I acknowledge and agree that the University is not responsible for my medical insurance or medical expenses. If I have dependents, all of my certifications, promises, acknowledgments, and agreements extend to my dependents as well as myself.

Student Signature: ____________________________ Date: ____________

janedoe@hawaii.edu

B. The section below must be completed by the health insurance company:

Name(s) of insured individual(s):

Doe, Jane

print full name

Doe, Jane

print full name

Insurance Provider: ACME Insurance Company

Policy Number/Plan Type: A00001234567 / Plan Type: PPP

Dates*: 1/1/2019 to 5/31/19

mm/dd/yyyy to mm/dd/yyyy

*While enrolled at UH, you are required to have health insurance. The plan/policy must meet ALL of the following minimum coverage requirements (all amounts are in USD). Vision/dental coverage is not required.

Agent: initial each line below to verify all coverage requirements.

- Comprehensive medical coverage = at least $100,000 US per accident/illness
- Inpatient/Outpatient medical (including mental health) coverage at no less than 75% usual/customary charge (UCC)
- Repatriation coverage = at least $25,000 US
- Medical evacuation coverage to home country = at least $50,000 US
- No more than $500 US deductible per accident or illness
- Waiting period for pre-existing conditions no longer than 6 months

I certify that the minimum coverage requirements stated above are provided by this policy/plan. I am qualified to make this determination as an authorized agent/employee of the above insurance provider.

Kevin Smith

Print Name:__________________________

kevin_smith@email.com / (702) 555-5555

Contact Information (email and/or phone number)

Signature: ____________________________

Title: Accounts Manager

Date: ____________

For UHM use only: Approved for Term: ____________ Until (date): ____________ By: ____________ Date: ____________

Disapproved for: Term: ____________ For: Insufficient coverage: ____________ Insufficient documentation: ____________ By: ____________ Date: ____________