AECP International Student Health Insurance Waiver

Coverage Date (listed on insurance card) ______________________________

☛ PLEASE PRINT LEGIBLY ☚

ASU Affiliate ID Number	Today's Date
Student's Last Name · First · MI	Date of Birth
Address · Apt.# · City · State · Zip	
ASU Email (required) ______________________	Telephone ______________
Tempe Campus	AECP College or School

Student's Signature______________________________________ Date______________

Please attach a copy of the following two items with this request:

1. A copy of your health insurance ID card
2. Written verification of coverage in English and US dollars.

Requests that are submitted without these two items will not be considered.

PLEASE KEEP A COPY OF THIS FORM FOR YOUR RECORDS.

FOR OFFICE USE ONLY

The Campus Health office certifies that the health insurance provides coverage as follows:

☐ **Policy effective date at least for the term of enrollment in AECP**

☐ **Lifetime Maximum Benefit is equal to or greater than $300,000**

☐ **Repatriation coverage is equal to or greater than $7,500**

☐ **Medical Evacuation coverage is equal to or greater than $10,000**

☐ **Includes coverage for primary and specialty care**

☐ **Includes coverage for hospitalization and emergency care**

Rec'd ___/___/____ Approved ☐ Denied ☐ By________ Date___/___/_____

Student Notified ___/___/_____

Notes____