

Health Insurance Waiver Request Form

All international students who carry valid I-20 issued by Olympic College must carry health insurance at all times, including annual vacation quarter and for the duration of OPT.

For students who wish to use different insurance coverage, they must request and obtain approval from Office of International Education & Study Abroad before your current coverage expires for continuing students or during orientation week for new students. Otherwise, you are automatically enrolled in Firebird Insurance every quarter, and is responsible for premium each quarter/session by the first day of each quarter.

- For coverage duration for each quarter, please visit <https://www.olympic.edu/current-students/office-international-education-study-abroad/medical-insurance>).
- Accident & sickness coverage must be an equivalent or more than the Firebird Insurance plan provides (\$500,000 USD for 2022-2023), and must also include medical repatriation coverage. Furthermore, any insurance coverage with reimbursement type will not be approved.
- Attach your coverage information which include duration of coverage, benefit coverage, and amount information. (Insurance Card & Certificate of Overseas Travel Insurance).

Name: _____ SID: _____

Address: _____

Phone Number: _____ OC Email: _____@student.olympic.edu

Office of International Education & Study Abroad

Please answer the following questions:

I am requesting to be waived from Firebird insurance for the following quarter(s).

Summer 20____ (Year); Fall 20____ (Year); Winter 20____ (Year); Spring; 20____ (Year)

The coverage is valid from _____ to _____.

U.S. phone number or/and billing office is available for local hospitals/clinics to contact in English to verify my coverage or/and where they can submit the bills directly.

Accident & sickness coverage is more than \$500,000 USD (for 2022-2023).

Deductible amount: \$_____ None

Medical repatriation coverage

Repatriation of remains coverage

I know how to use my insurance

- I can use my insurance at _
- Once hospitals/clinics/physicians issue a bill(s) for my medical treatment.....

I must submit the bill directly to my insurance company who will take care of the entire bill. I do not have to pay anything to the hospitals/clinics/physicians.

I must submit the bill directly to my insurance company who will take care of the entire bill. But I am responsible for my copay which is \$_____ for non-emergency visit and \$_____ for emergency visit.

I must pay the entire bill first, then I will submit reimbursement request to my insurance company. (Not approved)

My coverage information (in English), which include duration of coverage, benefit coverage, and benefit amount information is attached.

Student Signature: _____ Date: _____

Office Signature: _____ Date: _____ Approved Denied