Health Insurance Waiver Form

All UC Berkeley Extension international students are required to have medical insurance for the duration of their studies. The insurance is automatically included in your tuition fees; in order to be exempt from the plan you must complete this form and email it to Heike Helmer heikehelmer@berkeley.edu at least three weeks prior to the start of program. No waiver requests will be accepted after this date.

Personal Information

Family Name: ________________________________

First Name: ________________________________

Student ID: _________________________________

Email Address: ______________________________

In order to consider your waiver request, your insurance plan must meet ALL of the requirements AND be effective during the entire semester while registered.

Your proof of insurance with the summary of plan benefits need to be submitted with this waiver form. Please ensure your insurance meets the requirements on page 2.

Please Read Before Signing. I hereby certify that I have full health insurance coverage that meets the waiver requirements of UC Berkeley Extension (page 2). I am requesting to be waived from the group health insurance offered by the University of California Berkeley Extension. I accept full responsibility for all my medical expenses during the period of my enrollment at the University of California Berkeley Extension. I will also submit a health insurance waiver for each semester as long as I am a registered student at UC Berkeley Extension.

_________________________________________  ________________________
Signature                                      Date
Health Insurance Waiver Requirements

All UC Berkeley Extension international students are required to have medical insurance for the duration of their studies.

Health Insurance Waiver Requirements Check-List

To be waived from the school health insurance, you must be enrolled in a plan that meets ALL of the following requirements:

☐ I am enrolled in a medical health insurance plan through a recognized company that is owned, headquartered and operated in the United States. (Foreign insurance plan with U.S affiliates/representatives, travel insurance plans, and reimbursement program of any kind do not qualify.)

OR

☐ My private insurance plan provides:

☐ Policy written in English with benefits expressed in US dollars
☐ A minimum of $500,000 in benefits
☐ 100% coverage of hospitalization and emergency fees
☐ 100% coverage of professional fees
☐ At least 15 days of inpatient mental health services
☐ No pre-existing condition
☐ Payment of at least $50,000 for medical evacuation
☐ Payment of at least $25,000 for repatriation of remains
☐ An annual deductible of no more than $500
☐ A network provider facility within 10 miles of the UCB campus.

Please list name and address of facility: ____________________________________________
_______________________________________________________________

If you have checked all boxes on this list and listed the network facility within 10 miles of the UCB campus, you will be eligible to be waived from the school health insurance plan.

If you have any questions about waiving the health insurance, please contact:

International Student Services
E-mail: extension-intl@berkeley.edu
Phone: (510) 642-2564