UNITED HEALTHCARE

PACE UNIVERSITY INTERNATIONAL STUDENT

ACCIDENT AND SICKNESS INSURANCE

WAIVER FORM - 2019-2020

Pace University's policy requires each student to pay a Student Accident and Sickness Insurance premium charge for mandatory health insurance unless she/he satisfactorily demonstrates possession of appropriate and adequate coverage under a valid and comparable insurance policy. The University will remove the Student Accident and Sickness Insurance premium charge from your tuition bill **only** if you satisfactorily demonstrate coverage under another insurance policy. Your policy must cover incurred medical expenses for both accidents and sicknesses at a minimum of $250,000. Your policy must also cover Repatriation and Medical Evacuations at a minimum of $50,000 each. Your policy cannot have any pre-existing exclusions clause. Your Policy must also be effective for the time that you enter Pace University until you exit.

By signing this Waiver Form, you acknowledge your understanding and acceptance that any medical charges that you may incur from your own policy will solely and exclusively be your responsiblity for any and all such expenses.

Complete this Waiver Form and send it with a copy of your insurance policy (in English and in U.S. dollars) to The Allen J. Flood Companies, Inc. by email to pace@ajfusa.com, fax to 914.922.9212, or mail to Two Madison Avenue, Larchmont, NY 10538 attn: Pace University International Student Plan, no later than September 19, 2019 for annual coverage or February 11, 2020 for new students enrolling in the spring semester. You will receive an email reply from the plan administrator stating if your waiver was accepted or declined.

STUDENT'S NAME: _____
(LAST/FAMILY) (FIRST/GIVEN NAME) (MIDDLE INITIAL)

STUDENT ID#: (PLEASE PRINT) __ __ __ __ __ __ __ __ __ VISA STATUS OF INSURED STUDENT: _____

U.S. ADDRESS: (PLEASE DO NOT PROVIDE FOREIGN ADDRESS)

_____
(STREET) (CITY) (STATE) (ZIP)

WAIVED FOR: ◉ ANNUAL ○ SPRING/SUMMER ○ SUMMER I ○ SUMMER II ○ SINGLE Semester J1 only

OTHER INSURANCE INFORMATION (MUST BE COMPLETED)

NAME OF INSURANCE COMPANY _____

POLICY NO. _____

Name of Policyholder: _____ Relationship to Insured: _____

Visa Status of Policyholder: _____

STUDENT EMAIL: _____

SIGNATURE OF STUDENT: _____ DATE: _____

SIGNATURE OF POLICYHOLDER, IF OTHER THAN THE STUDENT _____ DATE: _____