



## International Health Insurance Waiver Request Form

(Students on OPT should use the [OPT Insurance Waiver Form](#))

The purpose of this form is to request cancellation of your International Health Insurance because you have other insurance that meets UM insurance requirements.

**Complete this form** & submit with below documents by email to [ihi@umich.edu](mailto:ihi@umich.edu). Please scan your documents, as our office does not accept photos of documents.

**Proof of Insurance:** A copy of your **insurance card/certificate** or **insurance contract**. If your insurance plan covers your dependents, please also attach proof that they are covered by the plan.

A copy of your **insurance plan booklet** in English. This information should include the **specific details** of your insurance coverage, including any **restrictions, limits, or exclusions in your coverage** while you are in the U.S..

Requests are usually evaluated within two weeks. You will receive email notification at **your UM email** once your request is approved or denied.

<b>LAST NAME</b>	<b>FIRST NAME</b>	<b>UM I.D. #</b>
<b>INSURANCE COMPANY:</b>		<b>POLICY NUMBER:</b>

<b>WAIVER START DATE:</b>		<b>WAIVER END DATE*:</b>	8/31/2024 <i>or</i> program end date (if earlier):
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\*Note: all waivers expire on August 31, and must be renewed each September.

**CHECK BELOW ONLY IF YOUR INSURANCE PROVIDED BY:**

**A SPONSOR** NAME OF SPONSOR \_\_\_\_\_

**A FAMILY MEMBER**

FAMILY MEMBER NAME	RELATIONSHIP	UM I.D. # (if UM employee)

<b>SIGNATURE</b>	<b>DATE</b>

For Office Use Only:

**APPROVED**

**DENIED**

Authorization: \_\_\_\_\_ Date: \_\_\_\_\_ Documents:  Attached  Imaged  None