STUDENT LIFE
INTERNATIONAL CENTER
UNIVERSITY OF MICHIGAN

International Health Insurance Waiver Request Form (OPT)

(For Students on Post-Completion OPT only)

The purpose of this form is to request cancellation of your International Health Insurance because you are now covered by insurance provided by your OPT employer. If your request is approved, a confirmation email will be sent to your U-M email address for your records.

☐ **Complete this form and scan together with the documents listed below & email to ihi@umich.edu. Use a scanner or a scanning app on your phone since we cannot accept photos of your documents.**

☐ **Proof of Insurance:** Attach a copy of your new insurance card (both front and back) OR a letter from your employer's human resources department including the date your health insurance coverage began. Include proof of insurance for any dependents as well.

LAST NAME	FIRST NAME	UMID #
INSURANCE COMPANY:		**DATE INSURANCE BEGAN:**

DATE TO CANCEL UM INSURANCE (see below note)**:**	

Note: The cancellation date must be the **last day of the month your new insurance began, unless your insurance started on the first business day of the month**, in which case you should enter the last day of the previous month. (For example, **if you start work on October 15, put "October 31" on the form. If you start work on October 1, put "September 30" on the form**.)

However, if the International Center does not receive this form **within 60 days** of the coverage start date, **the cancellation date will be last day of the month before the Center receives the form**. (For example, if your insurance started September 21, but the International Center does not receive this form until February 21, the cancellation date will be January 31.)

SIGNATURE	DATE

For Office Use Only: ☐ **APPROVED** ☐ **DENIED**

Authorization:______________________________ Date: _____________ Documents: ☐ Attached ☐ Imaged ☐ None

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