HACC requires all F-1 international students to subscribe to the HACC group health insurance plan through HTH Worldwide Insurance Services. There are very limited exceptions to this rule. If you believe that you qualify for one of the following exceptions, please complete this form and submit it with the appropriate documents. Submitting this form does not guarantee a waiver. Students will be notified within ten days of submitting this form whether it is approved. Students who submit a completed waiver and are approved will not be billed the insurance fee.

Note: Waiver application forms must be submitted every semester by September 15th for the Fall semester or by February 15th for the Spring semester or students will be held responsible for the semester insurance fee.

Date: ___________ Student Name: _____________________________ ID#: ______________

Semester/year for which you are requesting the waiver: _____________________________

Please select the type of waiver you are requesting:

_____ I receive medical insurance through my home country as a government benefit given to citizens or residents and it covers me during my studies in the U.S. **Proof of insurance coverage is required for this waiver. Please attach a copy of your insurance card.**

_____ I am covered as an eligible dependent on my sponsor or a family member’s insurance policy. **Proof of insurance coverage is required for this waiver. Please attach a copy of your insurance card and have page 2 of this form completed by the person who covers you as an eligible dependent.**

_____ I have been in the U.S. for over 5 years and I am considered a resident for tax purposes. I have enrolled in health insurance through healthcare.gov. **Submit proof of residency tax status such as a copy of most recent IRS form 8843 or 1040 and copy of health insurance card.**

_____ I am a guest student.

If my request for a waiver is approved, I acknowledge that I am responsible for maintaining adequate insurance coverage during my studies at HACC. I understand that medical treatment is costly in the U.S. and failure to carry medical insurance can lead to severe financial problems or inability to receive adequate medical treatment. I understand that in the event of serious injury or death the cost of medical evacuation and repatriation would fall on my surviving relatives and that this cost could exceed $25,000. I understand that Harrisburg Area Community College is not responsible for any medical expenses incurred during my studies.

Student Signature _____________________________________________ Date __________
Application for Health Insurance Waiver – Page 2 of 2

To be completed by primary insured sponsor or family member:

Name____________________________________________ Telephone__________________________

Address ____________________________________________________________________________

____________________________________________________________________________________

Name of Insurance Company___________________________________________________________

Member Identification Number/Policy Number___________________________________________

I affirm that (student name)__________________________________________________________ is covered
as a dependent on my medical insurance policy. I am aware that this insurance plan provides benefits
to treat covered injuries and sickness, but may NOT cover medical evacuation or repatriation of
remains in the event of severe injury or death of the student. I agree to be financially responsible for
all the necessary expenses actually incurred for the repatriation of the student’s remains to his
or her home country. Furthermore I agree to be financially responsible for the medically
necessary expenses incurred for a medical evacuation to the nearest hospital, appropriate
medical facility or back to the covered person’s home country if he or she sustains an injury or
suffers a sudden sickness while studying at Harrisburg Area Community College. I understand
that these expenses can easily exceed $25,000.

Signature of Primary Insured___________________________________________________________ Date________

For office use:
Received Date: ___/___/___
Approved________________________ Comments:
Denied__________________________
Spreadsheet updated ___/___/___
Health insurance canceled___/___/___
Cancellation Date___/___/___

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