Southeastern Louisiana University
International Insurance Waiver Form

This form should be completed only if you have comparable insurance coverage and are requesting to waive the Student Health Insurance Plan. Return completed waiver form to the International Services Office along with proof of health insurance coverage. Proof of coverage must include policy information, deductible rates, coverage benefits, and expiration date of policy. Waivers must be approved by the International Services Office.

Student Name: _____________________________________  W#: ___________________

Address (US): ______________________________________

Phone #: _____________________________  Date of Birth:  Month: _____  Day: _____  Year: ________

Name of Insurance Company/Claims Administrator: _____________________________________________

Policy Number: ____________________________________

Name of Policy Holder/Insured Persons: _______________________________________________________

Relationship of Policy Holder/Insured Person (If not student): ____________________________________

Phone # of Insurance Company/Claims Administrator to Verify Coverage: ________________________

Dates of Coverage:  From: _________________  To: _________________

Signature of Student: ______________________________  Date: ________________________

International Services Office • Southeastern Louisiana University • SLU Box 10752 • Ph: 985-549-2360 • Fax: 985-549-5882 • international@selu.edu