**PRINT FORM TO COMPLETE**

**PLEASE PRINT LEGIBLY**

**(exactly as your name appears in the payroll system)**

**LAST NAME**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FIRST NAME**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**STUDENT ID** #: **\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DATE OF BIRTH (**mm/dd/yyyy): \_\_\_\_\_\_\_\_\_\_\_\_\_

**UT EMAIL**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ @vols.utk.edu

**DEPARTMENT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SEMESTER: FALL / SPRING YEAR**: \_\_\_\_\_\_\_\_\_\_\_

 **(CIRCLE ONE)**

**EXPECTED GRADUATION DATE: \_\_\_\_\_\_\_\_\_\_\_\_**

****

**HEALTH INSURANCE FEE WAIVER**

**INTERNATIONAL GA/GRA/GTAS**

**UTK Student Health Center**

1800 Volunteer Blvd

Knoxville, TN 37916

**Email waiver to:** gradinsurancewaiver@utk.edu

(do not send regular correspondence to this email)

**I UNDERSTAND (PLEASE READ AND INITIAL EACH:**

\_\_\_I must maintain the minimal **25% appointment** for my department to pay the insurance premium

\_\_\_If I lose my assistantship for any reason, I will be charged for insurance

\_\_\_The cost of insurance is paid by the department **ONLY** for the months I maintain the minimal 25%

\_\_\_I will be enrolled as an international student and charged for insurance **BEFORE** I am confirmed in payroll

\_\_\_I will be enrolled as a GA/GRA/GTA **AFTER** I am confirmed in payroll

\_\_\_The insurance charge will not be removed from student account until **AFTER** tuition waiver is processed

\_\_\_The insurance charge **MIGHT NOT BE REMOVED** from my account before **August 31 (Fall) or January 31 (Spring)**

\_\_\_I must remain insured for the full academic year: **August 1 through July 31** (even after graduation)

\_\_\_If I **GRADUATE**, I need to contact the Student Health Center since I may be responsible for insurance charges

\_\_\_If I enter **OPT/CPT**, I need to contact the Student Health Center since I may be required to complete a waiver

\_\_\_If my **VISA/CITIZENSHIP** status changes, I must contact the Student Health Center immediately

\_\_\_If am treated at the UT Medical Center, I will be billed for services (copays, deductible, and coinsurance apply)

\_\_\_The per semester UT Programs & Services Fees (SPSF Part A/B)\* and how it is assessed

\*This fee **MUST** be paid to access the on campus UT SHC **AND** to qualify for “student pricing” at the UT Medical Center ER

**\*GRADUATING? OPT/CPT? VISA/CITIZENSHIP CHANGE?**

It is imperative that you contact the Student Health Center as soon as this information become available.

* As an international student, you MUST have uninterrupted insurance coverage each academic year from August 1 – July 31
* Failure to have uninterrupted coverage could be a violation of visa status.
* If you graduate or lose your assistantship at any time, you will be automatically enrolled with an international status and charges will be added to your student account for the months you are not employed between August 1 and July 31.

**I agree to pay charges for insurance if they are added to MyUTK account\_\_\_\_\_\_(initial here)**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(STUDENT SIGNATURE) (DATE)

STREET ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ APTARTMENT #:\_\_\_\_\_\_\_\_\_

CITY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ STATE: \_\_\_\_\_ ZIP:\_\_\_\_\_\_\_\_\_\_

PHONE NUMBER: (\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Please be sure to update this information in the payroll system

**------------------- DO NOT WRITE BELOW - STUDENT HEALTH SERVICE USE ONLY --------------**

FEE REMOVED FOR **FALL:** AUG SEP OCT NOV DEC

**SPRING:** JAN FEB MAR APR MAY JUN JUL

NOTES:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

AMOUNT REMOVED:\_\_\_\_\_\_\_ AMOUNT CHARGED:\_\_\_\_\_\_\_ WAIVER ENTERED BY:\_\_\_\_\_\_ DATE:\_\_\_\_\_\_\_\_

EFF 7/1/22