

PRINT FORM TO COMPLETE



**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)

PLEASE PRINT LEGIBLY

LAST NAME: _____
FIRST NAME: _____
VISA (CIRCLE ONE): **F1 F2 J1 J2 OTHER:** _____
STUDENT ID #: 000 _____
DATE OF BIRTH (mm/dd/yyyy): _____
UT EMAIL: _____ @vols.utk.edu
DEPARTMENT: _____
SEMESTER: **FALL / SPRING** YEAR: _____
(CIRCLE ONE)
EXPECTED GRADUATION DATE: _____

I UNDERSTAND (PLEASE READ AND INITIAL EACH):

- ___ The cost of the insurance is paid by my department **ONLY** for the months I am an active GA/GRA/GTA
- ___ I must maintain the minimal 25% GA/GRA/GTA appointment to qualify for an insurance fee waiver
- ___ If I lose my assistantship during the academic year, charges for insurance will be added to my Bursar account
- ___ 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 and the insurance fee will be removed **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 while actively enrolled as a student at UT Knoxville
- ___ I must advise the Student Health Center of my graduation date
- ___ I will not be automatically enrolled in the insurance plan after I graduate, but I may choose to be insured
- ___ 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

- If you lose your assistantship at any time during the academic, 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

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

(STUDENT SIGNATURE) (DATE)

STREET ADDRESS: _____ APARTMENT #: _____

CITY: _____ STATE: _____ ZIP: _____

DATE OF BIRTH (MM/DD/YYYY): _____ 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: _____