

Last name,	First name
University ID#	

**EMPLOYER PORTION**

Please accept this as verification that the above listed student is currently provided with health benefits through the insurance plan of the following individual which meet the requirements listed on the back of this form. These benefits are expected to remain in effect throughout their employment with our company.

Name of primary insured: \_\_\_\_\_

Insurance ID number of primary insured: \_\_\_\_\_

Insurance company name: \_\_\_\_\_

This plan also:

**DOES** Provide coverage for Repatriation of Remains\* and Emergency Evacuation\*\* defined below) to the student's country of legal citizenship.

**DOES NOT** cover Repatriation of Remains\* and Emergency Evacuation\*\* to their country of origin. The student must purchase privately a separate travel insurance (of their choice) and submit it in combination with this form.

*\*In the event of death, coverage for Repatriation of Remains will reimburse the cost of return of mortal remains to the student's country of legal citizenship.*

*\*\*Emergency Medical Evacuation will reimburse the cost of transport, equipment and/or personnel necessary to evacuate the student to the country of legal citizenship.*

Supervisor/HR Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Title: \_\_\_\_\_ Phone: \_\_\_\_\_

**STUDENT PORTION**

I understand I must provide this form **EACH TERM** I am enrolled for credits at Oregon State University. I must renew my full waiver application each fall term or at the end of my last waiver period, whichever comes first.

Student Signature \_\_\_\_\_ Date \_\_\_\_\_

Office Use Only			
Date Received/Initials:	Waiver approved Yes / No Waiver end date:	Plan code:	Entered in SYSHIP (initials):
Special notes:			