JOHNS HOPKINS
UNIVERSITY

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Office of the Dean
Registrar

International Visiting Medical Students and International Summer Anatomy Students
Waiver of Student Health Program medical insurance
Effective July 1, 2017

Johns Hopkins School of Medicine requires all students to have adequate health insurance. If the student is accompanied to the United States by his/her spouse and/or children, they must also have adequate health insurance. You may enroll in the School of Medicine Student Health Program (SHP). If you elect to waive enrollment for yourself and your eligible family members, we require that the alternative health coverage meet minimum criteria.

Travel Insurance is acceptable for international visiting medical students with appointments for nine (9) weeks (One Quarter) or less and international Summer Anatomy students provided the travel insurance is equivalent to what Johns Hopkins requires for all J-1 Exchange Visitors. See form for equivalency.

DEMOGRAPHIC INFORMATION *(Please print):*

LAST NAME: _____ FIRST NAME: _____ MIDDLE INITIAL: ___

DATE OF BIRTH (mm/dd/yyyy): ____/_____/_____

STATUS: PLEASE CHECK ONE:

____I am an international visiting medical student in the School of Medicine. I will be at Hopkins for nine weeks or less. I am requesting a health insurance waiver for myself and all eligible family members. The dates of my appointment are:
From (mm/dd/yyyy) _____ To (mm/dd/yyyy) _____

____I am an international student enrolled in the Summer Anatomy program at the School of Medicine. I am requesting a health insurance waiver for myself and all eligible family members.

ALTERNATIVE HEALTH COVERAGE INFORMATION (this section MUST be completed): A copy of the current health insurance card MUST be submitted with this Waiver form for each person covered by this Waiver form.

The person(s) waiving coverage in the Student Health Program are covered by other health insurance which meets all Johns Hopkins J-1 Exchange Visitor Health Insurance Requirements. The insurance plan in which I/they are enrolled is:

Insurance Company Name: _____

Name of primary subscriber: _____

Policy/Member Number: _____Effective date: _____

FINANCIAL RESPONSIBILITY STATEMENT

- **I verify that I have medical insurance which is equivalent to the J-1 Exchange Visitor Health Insurance Requirements or exceeds those minimum requirements.**
- **I understand that by waiving the Student Health Program sponsored by The Johns Hopkins University, I am accepting full financial responsibility for hospital, laboratory, physician, diagnostic testing and other medical costs not covered by my insurance.**
- **I acknowledge the risk of inadequate health insurance coverage could affect my finances and my credit standing.**

_____ _____

Signature of International Student **Date (MM/DD/YYYY)**