

International Student Health Insurance Cancellation Request Form



This form is designed to cancel the student health insurance coverage offered through VIU.

The deadline to cancel insurance coverage is the last day of the add/ drop period of each semester.

Today's Date: ____/____/____

Entering VIU: Fall ____ Spring ____ Summer I ____ Summer II ____ (Mark the year for the applicable semester)

Student's Name: _____

Student ID No./Social Security No.: _____

Local address: _____

E-mail: _____

Local Phone Number: _____

I am signing the International Student Health Insurance Cancellation Form because of either one or more of the following reasons (please check all that apply):

- I am transferring out of VIU to another institution.
- I have finished my studies and/or graduating, and do not want to continue my coverage during my OPT period.
- I have to leave VIU for a family emergency and have to leave the country.
- I have purchased international health insurance from a vendor outside of VIU. (You must provide proof of coverage that meets VIU's requirements of medical coverage and complete the Health Insurance Waiver Form. The insurance charge will not be waived or refunded until the waiver form has been completed and approved by the Student Services Office.)

Note: Students may be reinstated into the Student Health Insurance plan offered through VIU within 30 days of termination.

Once this form has been signed and approved by the Student Services Office, your coverage under the Student Health Insurance plan offered through VIU will be cancelled as follows:

- **Transfer Out:** The cancellation date of the student health insurance plan will be the day following the transfer of the student's F-1 SEVIS record from VIU. Refunds are calculated and issued within 45 days from this date.
- **Institutional Withdraw:** The cancellation date of the student health insurance plan will be the day following the termination of the student's F-1 SEVIS record at VIU. Refunds are calculated and issued within 45 days from this date.
- **Purchasing outside health insurance/OPT period begins/non F-1 Student:** Please select a cancellation date for the student health insurance plan (coverage must be continuously maintained while VIU holds the student's F-1 SEVIS record or until the student has graduated):

Cancellation Date: ____ / ____ / ____

Agreement: My signature at the end of this statement certifies the accuracy of the preceding information and serves as a request to cancel my coverage under the Virginia International University Student Health Insurance plan per VIU's policies for cancellation. Once my coverage is cancelled, I will no longer be covered under International Medical Group's plan.

Student Signature (or parent/guardian if under 18 years of age)

Date

Signature - Student Services Office

Date