Instructions for International Visiting Scholars:

1. **Take the “Insurance form” to your ISU departmental host** and ask him/her to complete the first item on the insurance form. Give them this document so they may follow their instructions below.

2. You, as the Visiting Scholar, will complete the rest of the insurance form, read the Agreement/Certification, sign and date.

3. **Return the completed form to** the University Human Resources, Service Center at 3810 Beardshear Hall **within 31 days of your arrival in the United States**.

4. **Waiver Request** - If you have health insurance that you purchased **before** arriving in the United States and you wish to use that insurance instead of the ISU health insurance, **you must follow steps 1 through 3 above**, complete the waiver form and return to the University Human Resources, Service Center 3810 Beardshear Hall **within 31 days of your arrival in the United States**.

   **Documents REQUIRED to waive the ISU Insurance Plan for you and dependents:**
   - A copy of your insurance information, detailed per the U.S. Department of State’s regulations (with English translation)
   - A copy of your Form I-94 stamped with your date of arrival
   - A completed Visiting Scholar Insurance form
   - **AND** a completed Visiting Scholar Waiver form

Instructions for Departments Hosting International Visitors:

1. Complete the “Department must complete” section on the Visiting Scholar Insurance Form.

2. Indicate if your visitor will pay for his/her own insurance or if the premiums should be billed to your department intramural.

3. The ISU host faculty member must sign his/her name.

4. Provide a departmental fund account number regardless of whom the paying party is going to be. **The reason the insurance office asks for an account number in all cases is that in the event the visitor's personal insurance is inadequate, or if he/she is billed for the coverage and defaults on the payment, the inviting department will be held financially responsible.**

5. Assist your visitor to return the completed forms to the University Human Resources, Service Center, 3810 Beardshear, within 31 days of his/her arrival in the United States.

6. **If visitor will be a Post Doc do not complete form.**

QUESTIONS: Direct all questions and concerns about the health insurance requirements and enrollment to University Human Resources, 3810 Beardshear Hall, isuuship@iastate.edu, 515-294-4800.
Iowa State University
Visiting Scholar Health Insurance Form

All Visiting Scholars are required to maintain qualifying health insurance coverage for themselves and their dependents throughout their stay at Iowa State University.

To enroll or waive the insurance, complete this form and return to University Human Resources, 3810 Beardshear within 31 days of your arrival in the United States.

1. **Department MUST Complete:**  
   This form will NOT be processed without this section completed

   **Billing Option:**
   - ☐ Visiting Scholar – billed via U-bill
   - ☐ Department – billed via intramural, Default billing if not specified

   Department ___________________________ Fund Account & Sec. Project ___________________________

   Accounting Contact ___________________ Department Collaborator ____________________________

2. **Scholar MUST complete:**

   Application for:
   - ☐ New Enrollment
   - ☐ Add Dependent(s)
   - ☐ Renewal/Extension
   - ☐ Request Waiver (attach waiver form and documents)

   **Arrival in U.S.** ___________________________ **Departure from ISU** ___________________________

   Last Name ___________________________ First Name ___________________________

   University ID number ___________________________ Date of Birth (mm/dd/year) ___________________________

   Mailing Address _________________________________________________________________

   City ___________________________ State _________ Zip Code ________________

   Gender ___ Male ___ Female

3. **Monthly Premium and Enrollment coverage is for (check one):**

   - ☐ Self Only $244.83 per month
   - ☐ Self & Spouse/Domestic Partner $489.67 per month
   - ☐ Self & 1 Child $448.67 per month
   - ☐ Self & 2 or more Children $652.50 per month
   - ☐ Self, Spouse/Domestic Partner & 1 Child $693.50 per month
   - ☐ Self, Spouse/Domestic Partner & 2 or more Children $897.33 per month

   Coverage is based on calendar months. Example: arrival date of January 20 and departure date of February 15 – total bill will be for 2 months of coverage. Premiums are not pro-rated for less than a month’s coverage.

4. **List All Covered Dependents:** (Dependent coverage is only available if the scholar is covered)

<table>
<thead>
<tr>
<th>Dependents</th>
<th>Last Name</th>
<th>First Name</th>
<th>Date of Birth</th>
<th>Gender (M/F)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spouse/Domestic Partner</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child</td>
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<tr>
<td>Child</td>
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</tr>
</tbody>
</table>

5. **Visiting Scholar Premium Billing Options:**

   - ☐ Monthly
   - ☐ Entire Stay within the current plan year

6. **Agreement/Certification:**

   The premium rates shown above are for the insurance period from August 1, 2015 through July 31, 2016. I understand that deductibles and copays are calculated on an annual basis starting August 1st of each year.

   I certify that, after this Enrollment Form was completed, I carefully and fully read it, that the statements and answers set forth are full, true, and correct, to the best of my knowledge and belief, and that no information required to be given either expressly or by implication, has been knowingly withheld. I understand that Aetna Life Insurance Company will rely upon the completeness and truthfulness of the information given and the statements made, and that if I have made any false statements or misrepresentations, or have failed to disclose or conceal any material fact, Aetna Life Insurance Company will be entitled to declare the health care contracts applied for void, and to refuse allowance of benefits to any person there under.

   I authorize any health care provider to release medical records to Aetna Life Insurance Company when reasonably related to the health care for which I have applied. If any law or regulation requires additional authorization for release of medical records, I will give this authorization.

   Scholar Signature: __________________________________________ Date: ________________

   Office Use Only
   DB ____ S5____
   Copy to Accnt ____