To request an exception to the mandatory purchase of Cardinal Care, this form must be completed on an annual basis and submitted to Vaden Health Center’s Insurance Office.

**SUBMIT VIA POSTAL MAIL OR DELIVERY SERVICE, OR DELIVER IN PERSON, TO:**

Vaden Health Center  
Insurance Office  
866 Campus Drive  
Stanford, CA 94305  

**FAX TO:**  
(650) 725-9970  

**EMAIL TO:**  
healthinsurance@stanford.edu

**STUDENT LAST NAME**  
**STUDENT FIRST NAME**  
**STANFORD UNIVERSITY I.D. NUMBER**  
**APPOINTMENT START AND END DATES**

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**I certify that the above-named individual has insurance coverage for the period of **
**BEGIN DATE** through **END DATE** which meets or exceeds the following:**

1. **Annual deductible less than $1,000 USD**  
   (If a foreign currency applies, please indicate the applicable amount.)
   - Yes  
   - No

2. **Lifetime benefit** (complete **a** or **b**):
   a. **Lifetime aggregate maximum benefits of at least $2,000,000 USD**  
      (If a foreign currency applies, please indicate the applicable amount.)
      - Yes  
      - No
   b. **Maximum per condition/per lifetime benefit of at least $500,000 USD**  
      (If a foreign currency applies, please indicate the applicable amount.)
      - Yes  
      - No

3. **Covers inpatient and outpatient medical care in the San Francisco Bay Area in the U.S.**
   - Yes  
   - No

4. **Covers inpatient and outpatient mental health care in the San Francisco Bay Area in the U.S.**
   - Yes  
   - No

5. **Covers prescriptions**
   - Yes  
   - No

6. **Covers non-emergency as well as emergency care**
   - Yes  
   - No

7. **Pre-existing conditions** (complete **a** or **b**):
   a. **Policy covers pre-existing conditions**
      - Yes  
      - No
   b. **The insured individual has met applicable waiting periods**
      - Yes  
      - No

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Although not a requirement of Stanford University, the U.S. Department of State requires that J1 visa holders have an insurance policy with minimum coverage of $25,000 USD for repatriation of remains and $50,000 USD for medical evacuation.

**NAME OF INSURANCE COMPANY**  
**INSURANCE POLICY NUMBER**

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**AGENT REPRESENTING INSURANCE COMPANY**  
**SIGNATURE OF AGENT**  
**DATE**

**TELEPHONE NUMBER**  
**ADDRESS**

**I have enrolled in the above insurance program and verify that the information contained herein is true and accurate. I will maintain this coverage for the period listed and will inform Vaden Health Center’s Insurance Office of all changes.**

**SIGNATURE OF STUDENT**  
**DATE**

7.2015