

FLORIDA INTERNATIONAL UNIVERSITY
INTERNATIONAL STUDENT HEALTH INSURANCE COMPLIANCE FORM

2006 - 2007

This form has been designed to assist international students in complying with the FIU rule requiring all international students to have insurance in order to register or enroll at FIU. Florida International University makes available a policy that meets the minimum standards of required coverage as per Rule 6C6.009(6), F.A.C. If you wish to purchase an alternate policy, you must provide proof that your proposed policy provides benefits at least equal to those required by FIU.

INSTRUCTIONS TO STUDENT: Ask your insurance company to complete this form and return it to:

International Student & Scholar Services
Florida International University
University Park, GC 355, Miami, FL 33199 or Biscayne Bay Campus, WUC 363, North Miami, FL 33181

FAX COMPLETED FORM DIRECTLY TO: (305)348-1521 University Park or (305)919-4824 for Biscayne Bay Campus

The insurance company must verify that the basic benefits listed below are included in your health insurance policy; if any of these benefits are not covered, **we cannot clear you to register for classes or continue enrollment at FIU.**

Release Information: I hereby permit my insurance company to release the following information to staff persons at Florida International University. Also, I understand the international insurance requirements established by FIU and agree to abide by them. I understand that alternate insurance policies are approved for limited periods not exceeding one year and that requirements for alternate policy coverage are subject to change. I further understand that I must have my policy reviewed at the end of the approval period indicated below.

I understand that, if alternate insurance is not approved, this does not mean that FIU or any of its employees, recommend that I cancel any existing, pending or proposed insurance coverage. A denial implies only that the policy presented does not meet the minimum criteria established by FIU with respect to specific medical insurance coverage criteria for registration and/or enrollment.

Print Name _____ Signature _____

PantherID#: _____ VISA TYPE: _____ MAJOR: _____ Date _____

INSTRUCTIONS TO INSURANCE COMPANY: Please complete the form on page 1 and 2. Indicate the insured's name and social security number, the insurance company name, U.S. claims agent/address/phone, policy number, and dates of commencement and termination of coverage. For items 1-14 state "YES" for every benefit covered or exceeded in the insured's policy and "NO" for benefits not covered or that do not meet the stated amounts of coverage. Please print your name and title and then sign and date the form on page 2.

Student Name _____
(family name) (first/given)

Insurance Co. Name _____ Policy #: _____

Dates of Coverage _____
(beginning) / (ending)

U. S. Claims Agent Address _____

U. S. Claims Agent Phone _____

Rule 6C-6.009(6) provides that "no foreign student in F-1, F-2, J-1, J-2 non-immigrant status shall be permitted to register or to continue enrollment at a (state) university (in Florida) without demonstrating that he or she has adequate medical insurance coverage for illness or accidental injury."

PLEASE NOTE: Students on J-1 and J-2 status sponsored by FIU will NOT be eligible to submit an alternate policy. These students are required to purchase the University approved policy.

The insurance policy must include the following basic benefits. Please state YES (meets minimum requirements) or NO (does not meet) for each item listed:

- _____ 1. Policy **must** provide continuous coverage for the entire period the insured is enrolled as an eligible student at FIU. Payment of benefits **cannot be limited to a specified period of time**, such as 52 weeks.
- _____ 2. Coverage is pre-paid and continuous for a minimum of **twelve months from August 20, 2006, or eight months beginning January 1, 2007.**
- _____ 3. Insurance proceeds are payable in U.S. Dollars.
- _____ 4. Claims agent must be located in the United States.

(1)

- _____ 5. Coverage is not restricted to a specific health care provider. Use of the policy is not restricted to a particular locale.
- _____ 6. The policy provides for coverage of major medical expenses at a minimum of 80% of usual, reasonable, and customary charges without specific limits on charges such as hospital room and board, hospital miscellaneous, physician visits, surgery, anesthesia, etc., up to a minimum of \$200,000.
- _____ 7. Exclusion for pre-existing conditions; not more than **first six months** from initial enrollment in the plan.
- _____ 8. Deductible is not greater than \$100 per accident or illness or \$500 per year.

- _____ 9. Inpatient and Outpatient mental health care paid as any other sickness for a maximum of 30 days per policy year.
- _____ 10. Maternity benefits treated as any other temporary medical condition.
- _____ 11. Inpatient/Outpatient Prescription Medication: Offers coverage of at least \$1,000 per policy year.
- _____ 12. The policy provides a minimum of \$10,000 for repatriation of remains to the home country.
- _____ 13. The policy provides a minimum of \$25,000 for medical evacuation to the home country, including expenses associated with an attendant, when medically necessary.
- _____ 14. The policy provides an aggregate cap of not less than \$200,000 per student for covered illnesses/injuries.

COMMENTS: Please indicate below any comments about the policy coverage and any of the above items:

TO THE INSURANCE COMPANY REPRESENTATIVE: Please read and sign the following. I have verified the information on this form and completed each item above. I certify that the coverage indicated is now in force. If the above noted policy is terminated, I will notify Florida International University, Office of International Student & Scholar Services, immediately.

Name _____ **Title** _____

Signature _____ **Date** _____

Telephone _____ **Fax** _____

_____ **FOR FIU OFFICE USE** _____

_____ **Approved until** _____

_____ **Denied because:**

_____ **subject to** _____ **not subject to**

_____ **high deductible**

Medical Evacuation/Repatriation

_____ **low major medical cap**

_____ **high co-payment percentage**

_____ **internal limits**

_____ **other** _____

_____ **ISSS Authorized Signature**

_____ **Date**