FLORIDA INTERNATIONAL UNIVERSITY
INTERNATIONAL STUDENT HEALTH INSURANCE COMPLIANCE FORM
ACADEMIC YEAR 2019-2020

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 for classes. FIU offers a policy that meets the minimum standards of required coverage as per Florida Board of Governors Rule 7(d) 6.009, F.A.C. If you wish to purchase an alternative policy, you must provide proof that your proposed policy provides benefits at least equal those required by FIU.

INSTRUCTIONS TO STUDENT: Ask your insurance company to complete this form and email or fax it directly to:

FIU Student Health Services
insure@fiu.edu
OR
Biscayne Bay Campus, North Miami, FL 33181, FAX: (305) 919-5312
OR Modesto A. Maidique Campus, Miami, FL 33199, FAX: (305) 348-3336

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, you will not be able to register for classes or continue enrollment at FIU.

Release of Information: I hereby permit my insurance company to release the following information to staff personnel 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 academic year and the 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: _____ Email: _____

Panther ID#: _____ Visa-Type: _____ Expected Graduation: _____

INSTRUCTIONS TO INSURANCE COMPANY: Please complete the form on page 1 and 2. Indicate the insured's name, the insurance company name, U.S. claims agent/address/phone, policy number, and dates of commencement and termination of coverage. For items 1-15 state "YES" for every benefit that meets or exceeded in the insured's policy. State "NO" for benefits not covered or that do not meet the stated minimum amount of coverage. Please print your name and title, then sign and date the form on page 2.

Student Name: _____ Date of Birth: _____
(Last/family name) (First/given name) (MM/DD/YYYY)

Insurance Co. Name: _____ Policy #: _____

U.S. Claims Agent Address: _____ U.S. Claims Agent Phone: _____

Dates of Coverage (MM/DD/YYYY; REQUIRED): _____/_____
Start Date End Date

The following minimum dates of coverage are required in order to register or continue enrollment:

Semester	**Dates of Coverage**
Fall 2020/Spring 2021/Summer 2021:	**August 17, 2020 to August 16, 2021**
Fall 2020:	**August 17, 2020 to December 31, 2020**
Spring 2021/Summer 2021:	**January 1, 2021 to August 16, 2021**

As per Florida Board of Governors, Section 7(d) Rule 6.009 (2) provides that "No international student in F or J non-immigrant status shall be permitted to register, or to continue enrollment, at a university without demonstrating that the student has adequate medical insurance coverage for illness or accidental injury and which includes the following minimum requirements."

INSTRUCTIONS: Please check YES (meets or exceeds minimum requirements) or NO (does not meet) for each item listed.

1.	YES□ NO□	Coverage Period: Policies must provide, at a minimum, continuous coverage for the entire period the insured is enrolled as an eligible student, including annual breaks during that period. Payment of benefits must be renewable.
2.	YES□ NO□	Basic Benefits: Room, board, hospital services, physician fees, surgeon fees, ambulance, outpatient services, and outpatient customary fees must be paid at 80% or more of usual, customary, reasonable charge per accident or illness, after deductible is met, for in-network, and 70% or more of usual, customary, and reasonable charge for out-of-network providers per accident or illness.
3.	YES□ NO□	Inpatient Mental Health Care: Must be paid at 80% in-network or 60% out-of-network of the usual and customary fees with a minimum 30-day cap per benefit period.
4.	YES□ NO□	Outpatient Mental Health Care: Must be paid at 80% in-network or 60% out-of-network of the usual and customary fees for a minimum of 30 (preferably 40) sessions per year.
5.	YES□ NO□	Maternity Benefits: Must be treated as any other temporary medical condition and paid at no less than 80% of usual and customary fees in-network or 60% out-of-network.
6.	YES□ NO□	Inpatient/Outpatient Prescription Medication: Must include coverage of $1,000 or more per policy year.
7.	YES□ NO□	Repatriation: $10,000 (coverage to return the student's remains to his/her native country).
8.	YES□ NO□	Medical Evacuation: $50,000 (to permit the patient to be transported to his/ her home country and to be accompanied by a provider or escort, if directed by the physician in charge).
9.	YES□ NO□	Deductible: Maximum of $50 per occurrence if treatment or services are rendered at the Student Health Center; maximum of $100 per occurrence if treatment or services are rendered at an off-campus ambulatory care or hospital emergency department facility.
10.	YES□ NO□	Minimum coverage: $200,000 for covered injuries/illnesses per policy year.
11.	YES□ NO□	Insurance Carrier must, at a minimum, meet the rating requirements specified in Part 62.14(c)(1) of Title 22 of the Code of Federal Regulations.
12.	YES□ NO□	Policy must not unreasonably exclude coverage for perils inherent to the student's program of study.
13.	YES□ NO□	Claims must be paid in U.S. dollars payable on a U.S. financial institution.
14.	YES□ NO□	Policy provisions must be available from the insurer in English.

NOTE: **Medical Evacuation and Repatriation (#7 and #8) benefits are available if and only if all other criteria have been approved.**

<u>TO THE INSURANCE COMPANY REPRESENTATIVE:</u> I have verified the information on this form and completed each item above. I certify that the following coverage indicated is now in force. <u>If the above noted policy is terminated, I will notify Florida International University, Student Health Services, immediately.</u>

Name:_____ Title:_____

Signature:_____ Date: _____

Telephone:_____ Fax: _____