INTERNATIONAL SCHOLAR HEALTH INSURANCE COMPLIANCE FORM
2024-2025

This form has been designed to assist international scholars in complying with the FIU, State of Florida and Department of State rule requiring all international scholars to have adequate insurance. Florida International University makes available a policy that meets the minimum standards of required coverage. 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 and the State of Florida.

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

International Student & Scholar Services
Florida International University
isss@fiu.edu | Ph:305-348-2421

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 accept the policy.

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 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.

Print Name _____ Signature _____

Panther ID: _____ Dept: _____ 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 1-16 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.

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

Insurance Co. Name _____

Policy #: _____ Dates of Coverage (Beginning - Ending) _____

Names of Dependents Covered _____

U. S. Claims Agent Address _____

U. S. Claims Agent Phone _____ Fax Number _____

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 provisions must be available from the insurer in English.

_____ 2. Insurance carrier must have an "A" rating or above per Part 62.14(d) (1) of Section 22 of the Code of Federal Regulations.

_____ 3. Basic Benefits: Hospital room and board, hospital services, physician fees, surgery, anesthesia, ambulance, outpatient services, and outpatient customary fees must be paid at 80% or more of usual, customary, reasonable charges per accident or illness after deductible is met, for in-network and 70% or more of usual, customary and reasonable charges for out of network providers per accident or illness.

_____ 4. Exclusion for Pre-existing Conditions: Not more than first 12 months from initial enrollment in the plan.

_____ 5. Deductible: Maximum $100 per occurrence. Total policy year deductible no more than $500 per year.

_____ 6. 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.

_____ 7. 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 sessions per year.

_____ 8. Maternity Benefits: Must be treated as any other temporary medical condition and paid at not less than 80% of usual and customary fees in-network or 60%out–of-network.

_____ 9. Inpatient/Outpatient Prescription Medication: Offers coverage of $1,000 or more per policy year.

_____ 10. Repatriation: The policy provides a minimum of $25,000 for repatriation to return the scholar's remains to his/her native country.

_____ 11. Medical Evacuation: The policy provides a minimum of $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.

_____ 12. Minimum Coverage: $100,000 per scholar for covered illnesses/injuries per accident or illness per policy year.

_____ 13. Policy must not unreasonably exclude coverage for perils inherent to the scholar's program.

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 _____
____ Subject to _____ not subject to medical evacuation/repatriation

____ Denied because:
____ high deductible
____ high co-payment percentage
____ internal limits
____ low major medical cap
____ other _____

ISSS Authorized Signature **Date**

REV. 09_04_24