FLORIDA INTERNATIONAL UNIVERSITY
INTERNATIONAL STUDENT HEALTH INSURANCE COMPLIANCE FORM
2009 – 2010

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 (3), F.A.C. If you wish to purchase an alternative 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:

University Health Services
Florida International University
University Park, Miami, FL 33199 OR Biscayne Bay Campus, North Miami, FL 33181

FAX COMPLETED FORM DIRECTLY TO: (305) 348-3336 University Park OR (305) 919-5312 for Biscayne Bay Campus
This form can be located at: www.fiu.edu/~health/internationalStudent.htm

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 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** ______________________________

Panther ID#: ____________________ **VISA-TYPE:** ____________________ **MAJOR:** ______________________________

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 1-17 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, 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 #:** ______________________________

Dates of Coverage (See below Benefit #2 for required dates) ____________________/________________________
(Beginning) / (Ending) (MM/DD/YYYY)

U.S. Claims Agent Address ____

U.S. Claims Agent Phone ______________________________________

As per Florida Board of Governors, 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.

REQUIRED BENEFITS 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 including annual breaks. Payments of benefits cannot be limited to a specific period of time, such as 52 weeks. Payment of benefits must be renewable.**

Students registering for Fall (the beginning of an academic year) have the option of pre-paying an annual premium or a semi-annual premium. The annual premium should cover from August 20, 2009 through August 19, 2010. The semi-annual premium should cover from August 20, 2009 through February 19, 2010. Students who paid the semi-annual payment for Fall must pay the second semi-annual premium covering February 20, 2010 through August 19, 2010 before they can register for Spring classes. Students who take classes for the first time beginning in Spring must have insurance coverage for January 1, 2010 through August 19, 2010 before they can register for Spring classes. Students who take classes for the first time beginning in Summer must have insurance coverage for May 1, 2010 through August 19, 2010 before they can register for Summer classes.

__________ 2. Coverage is pre-paid and continuous. Coverage must comply AS STATED DIRECTLY ABOVE.

__________ 3. Claims must be paid in U.S. Dollars payable on a U.S. financial institution.

__________ 4. Policy provisions must be available from the insurer in English.

__________ 5. Claims agent must be located in the United States.

__________ 6. Insurance carrier must have an "A" rating or above per part 62.14 (c) (1) of Section 22 of the Code of Federal Regulations.

__________ 7. 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 up to a minimum of $200,000.00 per accident or illness.

__________ 8. Exclusion for Pre-existing Conditions: Not more than first six months from initial enrollment in the plan.

__________ 9. Deductible: Maximum of $50 per occurrence if treatment or service is rendered at the University Health Center, maximum $100 per occurrence if treatment or service is rendered at an off-campus ambulatory care or hospital emergency room department. Total policy year deductible no more than $500 per year.

_________ 10. In patient 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.

_________ 11. 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.

_________ 12. 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.

_________ 13. Inpatient/Outpatient Prescription Medication: Offers coverage of $1,000 or more per policy year.

_________ 14. Repatriation: The policy provides a minimum of $10,000 for repatriation to return to the student's remains to his/her native country.

_________ 15. Medical Evacuation: The policy provides a minimum of $25,000 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.

_________ 16. Minimum coverage: $200,000 per student for covered illness/injuries per accident or illness per policy year.

_________ 17. Policy must not unreasonably exclude coverage for perils inherent to the student's program of study.

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

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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 following coverage indicated is now in force. If the above noted policy is terminated, I will notify Florida International University, University Health Services, immediately.

Name ____ Title ______________________________

Signature ____________________________________ Date ______________________________

Telephone ___________________________________ Fax _______________________________

FOR FIU OFFICE USE ONLY

_______ 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 __________________________

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University Health Services Authorized Signature Date

 FORM REV. 8/04/09