

F-1 INSURANCE COVERAGE EVALUATION FORM

NAME: \_\_\_\_\_ LSU ID NUMBER: \_\_\_\_\_

I certify that the above named individual and \_\_\_\_\_ dependents have insurance coverage for the period \_\_\_\_\_ through \_\_\_\_\_ which meets or exceeds the following as well as all mandated benefits:

Explain if NO:

- Medical and accident coverage up to \$50,000 per accident or illness OR \$100,000 minimum aggregate  YES  NO \_\_\_\_\_

- Maximum deductible of \$500. For multiple party plans \$500 per person.  YES  NO \_\_\_\_\_

- a U.S. representative physically located in the United States with a U.S. telephone number/contact who acts on behalf of insurance company/insurance plans: verification and processing ability  YES  NO \_\_\_\_\_

- Policy must cover office visits for non-emergency and emergency visits (No emergency care only policies will be accepted).  YES  NO \_\_\_\_\_

- Maternity visits must be paid as any other health condition.  YES  NO \_\_\_\_\_

- Minimum coverage of \$7,500 repatriation of remains.  YES  NO \_\_\_\_\_

- Minimum coverage of \$10,000 medical evacuation of the exchange visitor to his/her home country.  YES  NO \_\_\_\_\_

\*Repatriation and medical evacuation coverage can be assessed separately for those students/dependents with policies lacking the repatriation/ medical evacuation coverage requirements for \$7 per semester.

NAME OF INSURANCE COMPANY: \_\_\_\_\_

AGENT REPRESENTING INSURANCE COMPANY: \_\_\_\_\_

Please print name

Signature of Agent \_\_\_\_\_
Date \_\_\_\_\_
Policy No. \_\_\_\_\_
Phone number in United States \_\_\_\_\_
Address in United States \_\_\_\_\_

I have enrolled in the above insurance program and verify that the above is true and accurate. I will continue to maintain this coverage and will notify your office of any changes and provide appropriate documents of any changes. I will provide documentation of continuation of the required coverage upon expiration of the policy as stated above. Furthermore, I will provide the International Services with a new F-1 Insurance Coverage Evaluation Form each and every semester, regardless of the insurance coverage end dates stated on any previously submitted forms.

Signature of Student: \_\_\_\_\_ Date: \_\_\_\_\_

Any fraudulent or misrepresented information will result in an official student misconduct report to the LSU Dean of Students' Office and possible University suspension. Upon such findings, Louisiana State University will have no responsibility (legal or financial) to any health issues that apply to and have been incurred by me, including death. The ISO reserves the right to investigate the validity of private policy benefits in order to meet all listed requirements.