

Student Medical Insurance Office at Virginia Tech
ALTERNATIVE INSURANCE COMPLIANCE FORM FOR 2009/10 ACADEMIC YEAR

THIS FORM IS DUE BY September 1, 2009

INSTRUCTIONS TO STUDENTS: Please ask your insurance company to complete this form and return it to: **Student Medical Insurance Office, Virginia Tech, Mail Code 0361, Blacksburg, Virginia, 24061. U.S.A. FAX (540) 231-6237/ Phone (540) 231-6303.** Failure to purchase acceptable insurance will result in a registration block, which will prevent registration for fall classes.

STUDENT RELEASE INFORMATION: I hereby permit my insurance company to release the following information to staff at Virginia Tech. I understand that I must have my policy **re-certified annually, prior to each fall term registration.**

Student Name (last/family) _____ (first/given) _____
Student ID Number _____ Local Phone # _____ Email Address _____
Campus of Enrollment _____ Signature _____ Date _____
J-1 Student: Yes No

FOR INSURANCE COMPANY COMPLETION - ALL ITEMS MUST BE MET IN ORDER TO QUALIFY AS ALTERNATIVE INSURANCE.

Please state "YES" (YES=MEETS or EXCEEDS minimum requirements) or "NO" for each item listed:

INSURANCE COMPANY NAME _____ POLICY NUMBER _____
DATES OF COVERAGE (beginning) _____ (ending) _____

- ___ 1. The plan must offer adequate provider care within a 50 mile radius of campus of enrollment.
- ___ 2. Deductibles should be no more than \$300 per accident or sickness.
- ___ 3. Major Medical benefits of at least \$50,000 per insured per policy year
- ___ 4. Exclusions for **pre-existing conditions may be no more restrictive than the following:**
Pre existing means:
(1) a condition that manifests itself during the six month period immediately preceding the covered person's effective date under the policy, or (2) for which medical advice, diagnosis, care or treatment was recommended or received within six months immediately prior to the covered person's effective date under the policy. A pre-existing condition will be covered under the Plan once an insured has been continuously insured under the Plan for at least 12 consecutive months. There should be no pre-existing condition requirement, which excludes coverage permanently under the policy.
- ___ 5. **Inpatient mental health care** paid **at least 80%** for the usual and customary fees with a 25 day cap.
- ___ 6. **Outpatient mental health** – Minimum of 20 visits. 80% for visits 1-5, 50% for visits 6-20.
- ___ 7. Maternity benefits treated as any other illness under the plan.
- ___ 8. Offers **Prescription Medication** coverage (after co pays) with a minimum of \$1,000 per insured per policy year.
- ___ 9. The policy provides a **minimum of \$10,000** for "**repatriation of remains**" or "**medical evacuation**" to the home country.
- ___ 10. Coverage is valid for one year from Aug 1 or first day of enrollment in school, and effective through the following July 31 or last day of the month of the student's graduation.

FOR J-1 VISA HOLDERS- ADDITIONAL REQUIREMENT MUST BE MET:
___ Medical benefits of at least \$50,000 per accident or illness

Comments:

INSURANCE COMPANY REPRESENTATIVE: (Please read and sign). **By submitting this form I certify that the coverage indicated is now in force. If the above noted policy is terminated, I will notify the Student Medical Insurance at Virginia Tech, immediately, telephone 540-231-6303.**

Print Name _____ Title _____
Signature _____ Date _____
Telephone _____ Fax _____

For Student Medical Insurance Office Use: Approval Signature _____
Date of Approval _____ Date of Expiration _____