F-1 INSURANCE COVERAGE EVALUATION FORM

This form must be submitted (may be faxed at 225-578-1413 or e-mailed to jgoodlo@lsu.edu) to IS by Friday, September 3, 2010 (absolute deadline date).

NAME: ______________________________________ **LSU-ID: 89-**____________________
Please Print (Last Name, First Name)

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
(mm/dd/yy) (mm/dd/yy)
benefits (coverage must begin on or before 08/23/2010 and end on or after 12/11/2010 at minimum for Fall 2010):

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 to home country. ☐ **YES** ☐ **NO** _____________
(pre-existing conditions related deaths must be covered; coverage must remain in force during entire stay in the U.S.)

- Minimum coverage of $10,000 medical evacuation of the exchange visitor to home country. ☐ **YES** ☐ **NO** _____________
(pre-existing conditions related illnesses must be covered; coverage must remain in force during entire stay in the U.S.)

***Repatriation and medical evacuation coverage can be assessed separately for those students/dependents with policies lacking the repatriation/ medical evacuation coverage requirements for $8 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 the 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 ISO 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.