

# INTERNATIONAL STUDENT HEALTH INSURANCE COMPLIANCE FORM

This form has been designed to assist international students at The University of West Florida in complying with the State of Florida Board of Governors (BOG) rule 6C-6.009 requiring all students in F-1, F-2, J-1 and J-2 non-immigrant status to have health insurance in order to register or enroll in classes. The International Student Advisor has available policies that include the necessary basic benefits mandated by the BOG. Any international student who purchases an alternate policy must provide the Foreign Student Advisor with proof that the alternate policy provides these same basic benefits required by the BOG.

## THIS FORM IS TO BE COMPLETED BY THE INSURANCE COMPANY REPRESENTATIVE.

Instructions: Read carefully and make certain every blank is completed. For items 1-11 state "yes" for every benefit covered or exceeded in the insured student's policy and "no" for benefits no covered or that do not meet required amounts of coverage. Review the remaining requirements, respond to the statement in italics, complete, sign and date this form in the spaces provided. The completed form may be returned to the student or faxed directly to the International Student Office at 850-474-2915.

Student Name: \_\_\_\_\_ Student Date of Birth \_\_\_\_\_  
Insurance Company: \_\_\_\_\_ Policy #: \_\_\_\_\_  
Date Coverage Begins: \_\_\_\_\_ Date Terminates: \_\_\_\_\_

The insurance policy must include the following BASIC benefits: (state yes or no for each item listed)

- \_\_\_\_\_ 1. *Coverage Period*: Coverage must include the full year, including annual breaks, regardless of the student's terms of enrollment. The policy must provide continuous coverage for the entire period the insured is enrolled as an eligible student. Payment of benefits must be renewable.
- \_\_\_\_\_ 2. *Basic Benefits*: Room, board, hospital services, physician fees, surgeon fees, ambulance, outpatient services, and outpatient customary fees must be paid at 80% or more of usual, customary, reasonable charge per accident or illness, after deductible is met, for in-network, and 70% or more of usual, customary, and reasonable charge for out-of-network providers per accident or illness.
- \_\_\_\_\_ 3. *Inpatient 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-day cap per benefit period.
- \_\_\_\_\_ 4. *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 (preferably 40) sessions per year.
- \_\_\_\_\_ 5. *Maternity Benefits*: Must be treated as any other temporary medical condition and paid at no less than 80% of usual and customary fees in-network or 60% out-of-network.
- \_\_\_\_\_ 6. *Inpatient/Outpatient Prescription Medication*: Must include coverage of \$1,000 or more.
- \_\_\_\_\_ 7. *Repatriation*: \$10,000 (coverage to return the student's remains to his/her native country).
- \_\_\_\_\_ 8. *Medical Evacuation*: \$25,000 (permits the patient to be accompanied by a provider or escort if directed by the physician in charge).
- \_\_\_\_\_ 9. *Exclusion for Pre-Existing Conditions*: First six months of policy period, at most.
- \_\_\_\_\_ 10. *Deductible*: Maximum of \$50 per occurrence if treatment is rendered at the Student Health Center; maximum of \$100 per occurrence if treatment services are rendered at an off-campus ambulatory care or hospital emergency department facility.
- \_\_\_\_\_ 11. *Minimum Coverage*: \$200,000 for covered injuries/illnesses per accident or illness, per policy year.

**OTHER REQUIREMENTS:** Insurance Carrier must have an "A" rating or above per Part 62.14(c)(1) of Section 22 of the Code of Federal Regulations. Policy must not unreasonably exclude coverage for perils inherent to the student's program of study. Claims must be paid in U.S. dollars payable on a U.S. financial institution. Policy provisions must be available from the insurer in English.

**The insurance policy meets the minimum requirements as stated herein. YES \_\_\_\_\_ NO \_\_\_\_\_**

**I have completed and verified the information on this form and I have attached a copy, in English, of the student's policy and identification card.**

I represent \_\_\_\_\_ Insurance Company and certify the accuracy provided on this form.

Print Name: \_\_\_\_\_ Position: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_