

Print Name: _____ Student ID: N _____

INTERNATIONAL STUDENT HEALTH INSURANCE COMPLIANCE FORM

To comply with State of Florida rule 6C-6.009(6), international students must have health insurance. 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. Students in F-1, F-2, J-1 and J-2 status and their dependents are ALSO compelled by federal law to maintain health insurance coverage. The University of North Florida (UNF) has available a policy that includes the benefits mandated below. Before an international student can register for classes, the international student who purchases an alternate policy must provide Medical Compliance at UNF with proof that the alternate policy provides the mandated benefits. Only policies offered by insurers licensed and authorized to write health insurance by the State of Florida with a minimum of an A-rating are accepted. PLEASE PRINT LEGIBLY BELOW.

Student Release Information: I hereby permit my insurance company to release the following information to staff persons at UNF Medical Compliance. Also, I understand the international insurance requirements established by the University of North Florida and agree to abide by them. I understand alternate insurance policies are approved for limited periods not exceeding one year and that 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 and provide this information to the office of medical compliance at least yearly.

Without this alternate compliance form, when I register, I will be enrolled automatically in the (University of North Florida) Plan and an insurance fee will be added to my account.

Print Name: _____ Signature: _____

Student ID: N _____ Date: _____

THIS SECTION TO BE COMPLETED BY THE INSURANCE COMPANY. INSTRUCTIONS FOR INSURANCE COMPANY COMPLETING THIS FORM: Please read carefully the list of mandatory benefits. Fill in completely the information requested below. For item 1-11, state "yes" for every benefit covered or exceed in the insured student's policy and "no" for benefits not covered or that do not meet required amounts of coverage. Complete the remaining questions, print your name and position with the insurance company, and sign and date this form at the bottom of the page. In addition, please officially stamp this form. Completed information may be returned to the student or faxed directly to Medical Compliance at the University of North Florida at 904-620-2901.

Insured's Name:

(Last) _____ (First) _____ (Middle Initial) _____

Insurance company: _____ Policy Number: _____

U. S. Claims Agent Address: _____

U. S. Claims Agent Phone: _____

Date Coverage Begins: _____ Terminates: _____

The insurance policy must include the following mandated benefits*:

_____ 1. Coverage Period: **Coverage must include the academic year from the third week of August to the following third week of August.** Policy must provide continuous coverage for the entire period the insured is enrolled as an eligible student. Payment of benefits cannot be limited to a specific period of time (i.e., must be renewable). **Note:** For students beginning enrollment at the University of North Florida in the spring or summer terms, coverage must extend from at least the beginning of the term started to the third week of August. For students graduating in the fall term, coverage must extend through the first week of January.

_____ 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 with a minimum 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 per policy year.

_____ 7. Repatriation: \$10,000 (coverage to return the student's remains to his/her native country).

_____ 8. Medical Evacuation: \$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).

_____ 9. Exclusion for Pre-Existing Conditions: First six months of policy period, at most.

_____ 10. Deductible: Maximum of \$50 per occurrence if treatment or services are rendered at the Student Health Center; maximum of \$100 per occurrence if treatment or services are rendered at an off-campus ambulatory care or hospital emergency department facility.

_____ 11. Minimum coverage: \$200,000 for covered injuries/illnesses per policy year.

_____ 12. Insurance Carrier must have an "A" rating or above per Part 62.14(c)(1) of Section 22 of the Code of Federal Regulations.

_____ 13. Policy must not unreasonably exclude coverage for perils inherent to the student's program of study.

_____ 14. Claims must be paid in U.S. dollars payable on a U.S. financial institution.

_____ 15. Policy provisions must be available from the insurer in English.

_____ 16. Will student be eligible to purchase the insurance for the full year?

This insurance policy meets the minimum requirements listed above. YES _____ NO _____

A copy in English or the proof of coverage should be provided to Medical Compliance before the student enrolls in classes. **COMMENTS:** Please indicate below any comments about the policy coverage and any of the above items:

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 coverage indicated is now in force. If the above noted policy is terminated I will notify Medical Compliance at the University of North Florida immediately.

Print Name: _____ Position: _____
Signature: _____ Date: _____
Stamp: _____