

**FLORIDA INTERNATIONAL UNIVERSITY
GRADUATE ASSISTANT HEALTH INSURANCE COMPLIANCE FORM 2009 – 2010**

The FIU subsidized health insurance program is based on all Graduate Assistants participating in the program. Because the premiums in the FIU program are subsidized 75% by FIU's University Graduate School, it is unlikely that an alternate, comparable insurance program would be available at a cost less than the cost of your 25% premium. However, it is recognized that a few Graduate Assistants may have equivalent coverage under a spouse or parent plan. This form has been designed to assist the University Graduate School in making a determination of the equivalency of any alternate insurance plan. **This form must be completed in full by your insurance company and returned to the University Graduate School by the end of the add/drop period each semester.** For **Fall 2009** that date is **August 28, 2009**; for **Spring 2010**, that date is **January 8, 2010**; and for **Summer 2010**, that date is **May 7, 2010**. **It is the student's responsibility to ensure that the insurance company has faxed the form to the University Graduate School by the deadline.** *Incomplete forms or forms received after the deadline will not be considered and the payroll deductions for your 25% of the applicable premium will not be refunded.*

INSTRUCTIONS TO STUDENT: Ask your insurance company to complete this form and return it to:
University Graduate School
Florida International University
University Park, PC 230, Miami, FL 33199

FAX COMPLETED FORM DIRECTLY TO: (305) 348-3433

The insurance company must verify that the basic benefits listed below are included in your health insurance policy; if any of these benefits are not covered, **we cannot clear you to register for classes or continue enrollment at FIU.**

Release Information: I hereby permit my insurance company to release the following information to staff persons at Florida International University. Also, I understand the international insurance requirements established by FIU and agree to abide by them. I understand that alternate insurance policies are approved for limited periods not exceeding one year and those 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.

I understand that, if alternate insurance is not approved, this does not mean that FIU or any of its employees recommend that I cancel any existing, pending or proposed insurance coverage. A denial implies only that the policy presented does not meet the minimum criteria established by FIU with respect to specific medical insurance coverage criteria for Graduate Assistants.

Print Name _____ **Signature** _____
Panther ID#: _____ **VISA TYPE (if applicable):** _____
MAJOR: _____ **Date** _____

INSTRUCTIONS TO INSURANCE COMPANY: Please complete the form on page 1 and 2. Indicate the insured's name, the insurance company name, U.S. claims agent/address/phone, policy number, and dates of commencement and termination of coverage. For items 1-14 state **"YES"** for every benefit covered or exceeded in the insured's policy and **"NO"** for benefits not covered or that do not meet the stated amounts of coverage. Please print your name and title and then sign and date the form on page 2.

Student Name _____
(family name) _____ **(first/given)** _____
Insurance Co. Name _____ **Policy #:** _____
Dates of Coverage _____
(beginning) _____ **(ending)** _____
U. S. Claims Agent Address _____
U. S. Claims Agent Phone _____

Rule 6C-6.009(6) provides that "no foreign student in F-1, F-2, J-1, J-2 non-immigrant status shall be permitted to register or to continue enrollment at a (state) university (in Florida) without demonstrating that he or she has adequate medical insurance coverage for illness or accidental injury." PLEASE NOTE: Students on J-1 and J-2 status sponsored by FIU will NOT be eligible to submit an alternate policy. These students are required to purchase the University approved policy.

The insurance policy must include the following basic benefits. Please state YES (meets minimum requirements) or NO (does not meet) for each item listed:

- _____ 1. Policy **must** provide continuous coverage for the entire period the insured is enrolled as an eligible student at FIU. Payment of benefits **cannot be limited to a specified period of time**, such as 52 weeks. Payment of benefits must be renewable.
- _____ 2. Coverage is pre-paid and continuous for a minimum of **twelve months from August 20, 2009, or eight months beginning January 1, 2010.**
- _____ 3. Claims agent must be located in the United States, with policy provisions available (from the insurer) in English and Insurance proceeds payable in U.S. Dollars.

- _____ 4. Coverage is not restricted to a specific health care provider. Use of the policy is not restricted to a particular locale.
- _____ 5. The policy provides for coverage of major medical expenses such as basic benefits: Hospital room and board, hospital services, physician fees, surgery, anesthesia, ambulance, outpatient services, and outpatient customary fees paid at minimum of 80% of usual, customary, reasonable charges without specific limits per accident or illness after deductible is met, for in-network and 70% or more of usual, customary and reasonable charges for out of network providers up to a minimum of \$200,000 per accident or illness.
- _____ 6. Exclusion for pre-existing conditions; not more than **first six months** from initial enrollment in the plan.
- _____ 7. Deductible is not greater than \$100 per accident or illness or \$500 per year.
- _____ 8. 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.
- _____ 9. 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 sessions per year.
- _____ 10. Inpatient and Outpatient mental health care paid as any other sickness for a maximum of 30 days per policy year.
- _____ 11. Maternity benefits treated as any other temporary medical condition and paid at not less than 80% of usual and customary fees in-network or 60% out-of-network.
- _____ 12. Inpatient/Outpatient Prescription Medication: Offers coverage of at least \$1,000 per policy year.
- _____ 13. The policy provides a minimum of \$10,000 for repatriation of remains to the home country.
- _____ 14. The policy provides a minimum of \$25,000 for medical evacuation to the home country, including expenses associated with an attendant, when medically necessary.
- _____ 15. The policy provides an aggregate cap of not less than \$200,000 per student for covered illnesses/injuries per accident or illness per policy year.
- _____ 16. Policy must not unreasonably exclude coverage for perils inherent to the student's program of study.

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 Florida International University, University Graduate School, immediately.

Name _____ **Title** _____

Signature _____ **Date** _____

Telephone _____ **Fax** _____

FOR FIU OFFICE USE

___ **Approved until** _____

___ **Subject to** ___ **Not subject to**

___ **Medical Evacuation/Repatriation**

___ **Denied because:**

___ **high deductible**

___ **low major medical cap**

___ **high co-payment percentage**

___ **internal limits**

___ **other** _____

UGS Authorized Signature

Date