FLORIDA INTERNATIONAL UNIVERSITY
GRADUATE ASSISTANT HEALTH INSURANCE COMPLIANCE FORM
2006 - 2007

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, it is unlikely that an alternate, comparable insurance program would be available at a cost less than your 25%. 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 in each semester. For Fall 2006 that date is 5 September 2006 and for Spring 2007 that date is 16 January 2007.** *Incomplete forms or forms received after that date 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

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 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.

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 ____

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.

________ 2. Coverage is pre-paid and continuous for a minimum of **twelve months from August 20, 2006**, or **eight months beginning January 1, 2007**.

_______ 3. Insurance proceeds are payable in U.S. Dollars.

_______ 4. Claims agent must be located in the United States.

_______ 5. Coverage is not restricted to a specific health care provider. Use of the policy is not restricted to a particular locale.

_______ 6. The policy provides for coverage of major medical expenses at a minimum of 80% of usual, reasonable, and customary charges without specific limits on charges such as hospital room and board, hospital miscellaneous, physician visits, surgery, anesthesia, etc., up to a minimum of $200,000.

_______ 7. Exclusion for pre-existing conditions; not more than **first six months** from initial enrollment in the plan.

_______ 8. Deductible is not greater than $100 per accident or illness or $500 per year.

_______ 9. Inpatient and Outpatient mental health care paid as any other sickness for a maximum of 30 days per policy year.

_______ 10. Maternity benefits treated as any other temporary medical condition.

_______ 11. Inpatient/Outpatient Prescription Medication: Offers coverage of at least $1,000 per policy year.

_______ 12. The policy provides a minimum of $10,000 for repatriation of remains to the home country.

_______ 13. The policy provides a minimum of $25,000 for medical evacuation to the home country, including expenses associated with an attendant, when medically necessary.

_______ 14. The policy provides an aggregate cap of not less than $200,000 per student for covered illnesses/injuries.

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**

UGS REV: 08/07/06