

**FLORIDA INTERNATIONAL UNIVERSITY  
INTERNATIONAL STUDENT HEALTH INSURANCE COMPLIANCE FORM  
ACADEMIC YEAR 2020-2021**

This form has been designed to assist international students in complying with the FIU rule requiring all international students to have insurance in order to register for classes. FIU offers a policy that meets the minimum standards of required coverage as per Florida Board of Governors Rule 7(d) 6.009, F.A.C. If you wish to purchase an alternative policy, you must provide proof that your proposed policy provides benefits at least equal those required by FIU.

**INSTRUCTIONS TO STUDENT:** Ask your insurance company to complete this form and email or fax it directly to:

FIU Student Health Services  
[insure@fiu.edu](mailto:insure@fiu.edu)

OR

Biscayne Bay Campus, North Miami, FL 33181, FAX: (305) 919-5312  
OR Modesto A. Maidique Campus, Miami, FL 33199, FAX: (305) 348-3336

**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, you will not be able to register for classes or continue enrollment at FIU.**

**Release of Information:** I hereby permit my insurance company to release the following information to staff personnel 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 academic year and the 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 registration and/or enrollment.

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Email: \_\_\_\_\_  
Panther ID#: \_\_\_\_\_ Visa-Type: \_\_\_\_\_ Expected Graduation: \_\_\_\_\_

**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 1-15 state "YES" for every benefit that meets or exceeded in the insured's policy. State "NO" for benefits not covered or that do not meet the stated minimum amount of coverage. Please print your name and title, then sign and date the form on page 2.

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
(Last/family name) (First/given name) (MM/DD/YYYY)

Insurance Co. Name: \_\_\_\_\_ Policy #: \_\_\_\_\_

U.S. Claims Agent Address: \_\_\_\_\_ U.S. Claims Agent Phone: \_\_\_\_\_

Dates of Coverage (MM/DD/YYYY; REQUIRED): \_\_\_\_\_ / \_\_\_\_\_  
Start Date End Date

**The following minimum dates of coverage are required in order to register or continue enrollment:**

<b><u>Semester</u></b>	<b><u>Dates of Coverage</u></b>
Fall 2020/Spring 2021/Summer 2021:	August 17, 2020 to August 16, 2021
Fall 2020:	August 17, 2020 to December 31, 2020
Spring 2021/Summer 2021:	January 1, 2021 to August 16, 2021

As per Florida Board of Governors, Section 7(d) Rule 6.009 (2) provides that “No international student in F or J non-immigrant status shall be permitted to register, or to continue enrollment, at a university without demonstrating that the student has adequate medical insurance coverage for illness or accidental injury and which includes the following minimum requirements.”

**INSTRUCTIONS: Please check YES (meets or exceeds minimum requirements) or NO (does not meet) for each item listed.**

1.	YES <input type="checkbox"/> NO <input type="checkbox"/>	Coverage Period: Policies must provide, at a minimum, continuous coverage for the entire period the insured is enrolled as an eligible student, including annual breaks during that period. Payment of benefits must be renewable.
2.	YES <input type="checkbox"/> NO <input type="checkbox"/>	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.	YES <input type="checkbox"/> NO <input type="checkbox"/>	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.	YES <input type="checkbox"/> NO <input type="checkbox"/>	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.	YES <input type="checkbox"/> NO <input type="checkbox"/>	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.	YES <input type="checkbox"/> NO <input type="checkbox"/>	Inpatient/Outpatient Prescription Medication: Must include coverage of \$1,000 or more per policy year.
7.	YES <input type="checkbox"/> NO <input type="checkbox"/>	Repatriation: \$10,000 (coverage to return the student’s remains to his/her native country).
8.	YES <input type="checkbox"/> NO <input type="checkbox"/>	Medical Evacuation: \$50,000 (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.	YES <input type="checkbox"/> NO <input type="checkbox"/>	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.
10.	YES <input type="checkbox"/> NO <input type="checkbox"/>	Minimum coverage: \$200,000 for covered injuries/illnesses per policy year.
11.	YES <input type="checkbox"/> NO <input type="checkbox"/>	Insurance Carrier must, at a minimum, meet the rating requirements specified in Part 62.14(c)(1) of Title 22 of the Code of Federal Regulations.
12.	YES <input type="checkbox"/> NO <input type="checkbox"/>	Policy must not unreasonably exclude coverage for perils inherent to the student’s program of study.
13.	YES <input type="checkbox"/> NO <input type="checkbox"/>	Claims must be paid in U.S. dollars payable on a U.S. financial institution.
14.	YES <input type="checkbox"/> NO <input type="checkbox"/>	Policy provisions must be available from the insurer in English.

**NOTE: Medical Evacuation and Repatriation (#7 and #8) benefits are available if and only if all other criteria have been approved.**

**TO THE INSURANCE COMPANY REPRESENTATIVE: I have verified the information on this form and completed each item above. I certify that the following coverage indicated is now in force. If the above noted policy is terminated, I will notify Florida International University, Student Health Services, immediately.**

Name: \_\_\_\_\_ Title: \_\_\_\_\_  
 Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_