



INTERNATIONAL STUDENT HEALTH INSURANCE COMPLIANCE FORM

To comply with the State of Florida and Florida State University rules and regulations, all international students must show proof of adequate health insurance to register or enroll in university classes. Florida State University has a policy available that includes the mandated benefits. International students who purchase a policy from another carrier must provide Thagard Student Health Center with proof that the alternate policy provides the mandated benefits.

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

INSTRUCTIONS: Read carefully and make certain every blank is completed. For item 1-11, state "yes" for every benefit covered or exceeded in the insured student's policy and "no" for benefits not 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 Thagard Student Health Center Insurance Office at 850-644-4251.

Student name (last/first/middle) \_\_\_\_\_

Social security number: \_\_\_\_\_

Insurance Company Name, Address, Telephone Number: \_\_\_\_\_

\_\_\_\_\_

Insurance Policy Number: \_\_\_\_\_

Date coverage Begins: \_\_\_\_\_ Terminates: \_\_\_\_\_

The insurance policy must include the following mandated benefits:

- \_\_\_\_\_ 1. Coverage Period: 52 continuous weeks
- \_\_\_\_\_ 2. Basic Benefits: Room, board, hospital services, physician fees, surgeon fees, ambulance, outpatient services, and outpatient customary fees paid at 80% or more of usual, customary, reasonable (UCR) charge per accident or illness, after deductible is met, for in-network, and 70% or more of usual, customary, 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, customary fees with 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, customary fees for a minimum of 30 (preferable 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, customary fees in-network and 60% out-of-network.
- \_\_\_\_\_ 6. Inpatient/Outpatient Prescription Medication: Must include coverage of \$1000 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 (permits 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.

**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 unreasonable exclude coverage for perils inherent to the student's program of study. Claims must be paid in US dollars payable on a US 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 represent \_\_The Insurance Company of The State of Pennsylvania, (AIG Group) NAIC # 19429\_\_Insurance Company and certify the accuracy of information provided on this form.

Print name: \_Jesse Heim III, Florida Agent # E000048\_\_\_\_\_ Position: \_\_Broker & Managing Director\_\_

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

FAX FOR ENDORSEMENT: 1-817-738-4090