

**Florida Atlantic University ~ Division of Student Affairs ~ International Student and Scholar Services**

Boca Raton Campus: 777 Glades Road, SU 214, Boca Raton, FL 33431

Tel. (561) 297-3049 Fax: (561) 297-2446

Davie Campus: Multicultural Affairs (MD-G 13), 2912 College Avenue, Davie, FL, 33314

Tel. (954) 236-1257 Fax: (954) 236-1213

MacArthur Campus: Diversity Services (SR 117), 5353 Parkside Dr., Jupiter, FL 33458

Tel. (561) 799-8585 Fax: (561) 799-8721

**Email (all locations): [iss@fau.edu](mailto:iss@fau.edu)**

**ALTERNATE INSURANCE COMPLIANCE FORM FOR INTERNATIONAL STUDENTS  
2009-2010 Academic Year**

**Insurance Requirement for International Students in F and J Visa Status**

All international students are permitted to enroll at Florida Atlantic University (FAU) only after demonstrating that they hold medical insurance coverage which meets the guidelines set by the federal government, the State of Florida, the Florida Board of Governors and Florida Atlantic University, as applicable. J-1 students and their J-2 dependents are required by federal law to maintain health insurance coverage during the entire duration of their association with FAU (including any period authorized for academic training). J-1 students must purchase the FAU-procured plan and cannot use an alternate plan for complying with the insurance requirement. F-1 students may purchase the FAU-procured plan or provide proof of an acceptable alternate medical insurance plan. F-1 students who wish to purchase (or currently hold) an alternate policy must provide proof that the alternate policy provides the mandated benefits. **Misrepresenting or willfully failing to maintain appropriate medical insurance coverage will result in serious consequences for the student, including but not limited to loss of FAU sponsorship and class registration.**

The **Alternate Insurance Compliance Form** is designed to assist F-1 Students in complying with the insurance requirement if choosing not to enroll in the FAU-procured plan. This form must be completed each academic year. Students must complete section I and the insurance company must complete section II. FAU reserves the right to request a copy of the insurance policy and to further inquire about the policy as needed.

**SECTION I: TO BE COMPLETED BY THE STUDENT**

Name: \_\_\_\_\_

Last/Family/Surname

First/Given

Middle

FAU ID (Z#) \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Month/Day/Year

Immigration Status: F-1 \_\_\_\_\_ J-1 \_\_\_\_\_ J-2 \_\_\_\_\_ Other (explain): \_\_\_\_\_

Address: \_\_\_\_\_

Street/Apartment #

City

State

Zip Code/Country

Contact Information: \_\_\_\_\_

Telephone #

Cell Phone#

Email Address

Policy Information: \_\_\_\_\_

Company Name

Policy/Group Number

**Student Acknowledgment and Release:** I understand the international student insurance requirements established by FAU and I agree to abide by them. I understand that alternate insurance policies are approved for periods not exceeding one year at a time, and requirements are subject to change. If the alternate insurance is not approved, this does not mean that FAU 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 FAU with respect to specific medical insurance coverage criteria required for registration and/or enrollment. Furthermore, I understand that I must have my policy recertified annually prior to each fall semester registration.

I hereby give permission to my insurance company representative to complete and return this form to the address or fax number listed below:

*International Student and Scholar Services, Florida Atlantic University, SU 80 Suite 214, 777 Glades Road, Boca Raton, FL 33431, USA, Phone: 561-297-3049, Fax 561-297-2446, Email: [iss@fau.edu](mailto:iss@fau.edu).*

\_\_\_\_\_  
Student's Signature

\_\_\_\_\_  
Date

**SECTION II: TO BE COMPLETED BY THE INSURANCE COMPANY**

**Return this form to:** *International Student and Scholar Services, Florida Atlantic University, SU 80 Suite 214, 777 Glades Road, Boca Raton, FL 33431, USA, Phone: 561-297-3049, Fax 561-297-2446, Email: [jsss@fau.edu](mailto:jsss@fau.edu).*

Student's Name (Last, First, Middle): \_\_\_\_\_  
 Student's Date of Birth (Month, Day, Year) \_\_\_\_\_  
 Insurance Agency & Agent Name: \_\_\_\_\_  
 U.S. Claims Agent Address: \_\_\_\_\_  
 U.S. Claims Agent Contact: \_\_\_\_\_  
 Telephone# \_\_\_\_\_ Fax# \_\_\_\_\_ Email Address \_\_\_\_\_  
 Policy Number: \_\_\_\_\_ Coverage begins on \_\_\_\_\_ and ends on \_\_\_\_\_

**Please review the requirements and complete the acknowledgment listed below:**

1. Claims: The alternate policy has a claims agent located in the United States.
2. Coverage Period: Coverage includes the academic year from the third week of August 2009 to the following the third week of August 2010. Policy must provide continuous coverage for the entire period the insured is enrolled as an eligible student. Policy is prepaid and/or non-cancelable for the entire coverage period. Payment of benefits cannot be limited to a specific period of time (i.e., must be renewable).  
**NOTE:** For students beginning enrollment at FAU 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.
3. 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 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.
4. Inpatient Mental Health Care: Paid at 80% in-network or 60% out-of-network of the usual and customary fees with a minimum 30-day cap.
5. Outpatient Mental Health Care: 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.
6. Maternity Benefits: 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.
7. Inpatient/Outpatient Prescription Medication: Offers coverage of \$1000 or more.
8. Exclusion for Pre-Existing Conditions: First six months of policy period at most.
9. Deductible: \$50 per occurrence if treatment or services are rendered at a SHC, or \$350 cumulative per policy year.
10. Minimum coverage: \$200,000 for covered injuries/illnesses per accident or illness, per policy year, with no internal caps or limitations for covered injuries or illnesses.
11. Insurance Carrier must be "A" rating or above per Para 62.14(c) (1) of the Code of Federal Regulations.
12. Policy may not unreasonably exclude coverage for perils inherent to the student's program of study.
13. Claims are paid in U.S. dollars payable on a U.S. financial institution.
14. Policy provisions available from insurer in English.
15. Policy premiums shall be refundable if student is no longer eligible for policy (in no other instances shall the policy be refundable).
16. Repatriation: \$10,000 (coverage to return the student's remains to his/her native country).
17. Medical Evacuation: \$25,000 (permits the patient to be transported to their home country and to be accompanied by a provider or escort if directed by the physician in charge).

**Acknowledgment:** Policy# \_\_\_\_\_ issued by (company name) \_\_\_\_\_ to (student's name) \_\_\_\_\_ for the period from \_\_\_\_\_ to \_\_\_\_\_  
 Month/Day/Year Month/Day/Year

**meets** \_\_\_ **does not meet** \_\_\_ the above requirements 1 through 15 and  
**meets** \_\_\_ **does not meet** \_\_\_ the above requirements 16 and 17.

I certify that the information above is true and accurate and I have verified the information pertaining to each of the requirements noted above. I understand that Florida Atlantic University is relying on these representations in permitting this student to register or continue enrollment. If the above policy is terminated, I will notify Florida Atlantic University immediately.

Company Representative: \_\_\_\_\_

Name Position

Contact Information: \_\_\_\_\_

Telephone Fax Email

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

*Note: Policies that meet requirements 1 through 15 will be accepted if students purchase a separate insurance rider for medical evacuation and repatriation (items 16 and 17). Students have the option to purchase this rider at FAU.*