

**Florida Atlantic University**  
**International Student and Scholar Services**  
**ALTERNATE INSURANCE COMPLIANCE FORM**

This form is designed to assist international students to comply with FAU and State of Florida rules and regulations requiring all international students to have health insurance in order to register or enroll at FAU. Students in J-1 status and their dependents are also compelled by federal law to maintain health insurance coverage during their entire duration of stay at FAU. Misrepresenting or willfully failing to maintain coverage will result in students facing serious consequences. Florida Atlantic University makes available a policy that includes the benefits mandated below. Any international student who purchases an alternate policy must provide the office of International Student and Scholar Services with proof that the alternate policy provides the mandated benefits. Only policies offered by insurers licensed and authorized to write health insurance by the State of Florida with a minimum of an A- rating are accepted.

**INSTRUCTIONS TO STUDENT:** Please ask your insurance company to complete this form and return or fax it to:

**International Student & Scholar Services,  
 Florida Atlantic University, SSB 214  
 777 Glades Road, Boca Raton, FL 33431, U.S.A.  
 FAX: (561) 297-2446 / PHONE: (561) 297-3049.**

The proposed alternate policy must have a Claims Agent in the United States. 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 FAU. **Please allow sufficient time for processing this form.**

**STUDENT RELEASE INFORMATION:** *I hereby permit my insurance company to release the following information to the staff at Florida Atlantic University. Also, I understand the international insurance requirements established by Florida Atlantic University 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 re-certified annually, prior to each FALL term registration.*

*I understand that, 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.*

Print Name \_\_\_\_\_ Signature \_\_\_\_\_ Date: \_\_\_\_\_  
 Social Security or Student Number \_\_\_\_\_ Local Phone # \_\_\_\_\_  
 FAU E-Mail Address \_\_\_\_\_@fau.edu Visa Type \_\_\_\_\_  
MM/DD/YY

**THIS SECTION TO BE COMPLETED BY THE INSURANCE COMPANY**

**INSTRUCTIONS TO INSURANCE COMPANY COMPLETING THIS FORM:** Please read carefully the list of mandatory benefits. Fill in completely the information requested below. For items 1-16, 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. Complete the remaining questions, print your name and position with the insurance company, and sign and date this form at the bottom of the page. Completed information must be faxed directly to *International Students and Scholars Office Fax # 561-297-2446*

Insured's Name

(Last) \_\_\_\_\_ (First) \_\_\_\_\_ Middle Initial \_\_\_\_\_

Insured's Date of Birth: \_\_\_\_\_ Immigration Status \_\_\_\_\_

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

Insurance Agency & Agent Name: \_\_\_\_\_

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

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

Date coverage begins: \_\_\_\_\_ /terminates: \_\_\_\_\_

**International students are not permitted to register or to continue enrollment at FAU without demonstrating compliance with the insurance requirements.**

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**Florida Atlantic University**  
**International Student and Scholar Services**

**FOR INSURANCE COMPANY COMPLETION**

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Please state "YES" (MEETS or EXCEEDS minimum requirements) or "NO"(DOES NOT MEET minimum requirements) for items:

Student Last Name \_\_\_\_\_ Student First Name \_\_\_\_\_

Student Date of Birth \_\_\_\_\_ Student ID \_\_\_\_\_

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

- \_\_\_\_\_ 1. Coverage Period: Coverage must include the academic year from the third week of August 2008 to the following third week of August 2009. Policy must provide continuous coverage for the entire period the insured is enrolled as an eligible student. Policy must be 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.
- \_\_\_\_\_ 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 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. 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.
- \_\_\_\_\_ 4. 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.
- \_\_\_\_\_ 5. 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.
- \_\_\_\_\_ 6. Inpatient/Outpatient Prescription Medication: Offers coverage of \$1000 or more.
- \_\_\_\_\_ 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 their 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: \$50 per occurrence if treatment or services are rendered at a Student Health Center (SHC), \$100 per occurrence if treatment or services are not rendered at a SHC, or \$350 cumulative per policy year.
- \_\_\_\_\_ 11. 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.
- \_\_\_\_\_ 12. Insurance Carrier must be "A" rating or above per Para 62.14(c) (1) of the Code of Federal Regulations.
- \_\_\_\_\_ 13. Policy may not unreasonably exclude coverage for perils inherent to the student's program of study.
- \_\_\_\_\_ 14. Claims paid in U.S. dollars payable on a U.S. financial institution.
- \_\_\_\_\_ 15. Policy provisions available from insurer in English.
- \_\_\_\_\_ 16. Policy premiums shall be refundable if student is no longer eligible for policy (in no other instances shall the policy be refundable).

**COMMENTS:** Please indicate below any comments about the policy coverage and any of the above items.

\_\_\_\_\_  
\_\_\_\_\_

**INSURANCE COMPANY REPRESENTATIVE:** (Please read and sign.) *I have verified the information on this form and completed each item above. I certify that the coverage indicated is now in force. I understand that Florida Atlantic University is relying on these representations in permitting the student to register or continue enrollment. If the above noted policy is terminated, I will notify Florida Atlantic University, immediately.*

Signature of Representative: \_\_\_\_\_

Name: \_\_\_\_\_ Date \_\_\_\_\_ Phone # \_\_\_\_\_  
Month / Day / Year

Company: \_\_\_\_\_ Title \_\_\_\_\_

ISSS Approved By \_\_\_\_\_ Date \_\_\_\_\_