FLORIDA ATLANTIC UNIVERSITY
INTENSIVE ENGLISH INSTITUTE
ALTERNATE INSURANCE COMPLIANCE FORM

This form is designed to assist international students 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. 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 Intensive English Institute 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: **Intensive English Institute, Florida Atlantic University, 777 Glades Road, CEH 204, Boca Raton, FL 33431-0991, U.S.A., FAX: (561) 297-3987/PHONE: (561) 297-0179.** ***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.**

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

I understand that, if 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 ________
(MM/DD/YY)

Local Phone # __________ ___________________________ Email Address ___________________________

INSTRUCTIONS TO INSURANCE COMPANY COMPLETING THIS FORM: Please read carefully the list of mandatory benefits. Fill in completely the information requested below. For items 1-15, 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 page 2. Completed information must be faxed or sent directly to the Intensive English Institute. Fax: 561-297-3987

Insured's Name (last/family) ________________________________ (first/given) ___________________________

Insurance Carrier ________________________________ Policy Number ___________________________

Insurance Agency & Agent Name ____

U.S. Claims Agent Address ____

U.S. Claims Agent Phone ________________________________ US. Claims Agent Fax ___________________________

Date coverage begins ___________________________ /terminates __________ ___________________________
Month/Day/Year Month/Day/Year

International students are not permitted to register or to continue enrollment at FAU without demonstrating compliance with the insurance requirement. The University is unable to make any exceptions to this rule.

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FOR INSURANCE COMPANY COMPLETION

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

______ 1. Basic Benefits: Room, board, hospital services, physician fees, surgeon fees, ambulance, outpatient services, and out patient customary fees paid at 80% or more of usual, customary, reasonable charge per accident or illness, after deductible is met, for in-network, and 60% or more of usual, customary, and reasonable charge for out-of-network providers per accident or illness.

______ 2. Inpatient Mental Health Care: Paid at 80% of the usual and customary fees with a minimum 30-day cap.

______ 3. Outpatient Mental Health Care: Paid at 80% of the usual and customary fees for a minimum of 20 days per year.

______ 4. Maternity Benefits: Treated as any other temporary medical condition and paid at no less than 80% of usual and customary fees.

______ 5. Inpatient/Outpatient Prescription Medication: Offers coverage of $1,000 or more.

______ 6. Repatriation: $10,000 (coverage to return the student's remains to his/her native country).

______ 7. 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).

______ 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 Student Health Center (SHC) $100 per occurrence if treatment or services are not 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 unreasonable exclude coverage for perils inherent to the student's program of study.

______ 13. Claims 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).

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's Intensive English Institute 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, Intensive English Institute, immediately.

Print Name ______________________________ Title ______________________________

Signature ______________________________ Date ______________________________
Month/Day/Year

Telephone ______________________________ Fax ______________________________

For FAU Office Use: Approval Signature ______________________________

Date of Approval ______________________________ Date of Expiration ______________________________
MM/DD/YY MM/DD/YY

(revised 3/08)