

**UNIVERSITY OF MIAMI**

**International Student Health Insurance Compliance Form**

This form has been designed to assist international students in complying with the University of Miami regulation requiring all international students to have health insurance when attending the university. This policy is charged to you at time of registration. If you have already purchased an alternate policy, you **must** provide proof that your policy provides benefits at least equal to those required by the University of Miami.

**INSTRUCTIONS TO STUDENT:**

Ask your insurance company to complete this form and return it to:

University of Miami Student Health Service  
Attention: International Insurance  
5513 Merrick Drive  
Coral Gables, FL 33146-5310  
**Fax completed form to: 305-284-4905**

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 waive the international health insurance charge.

**Deadline for waiver request Fall term: September 1, 2005**

**Waivers will only be granted if you meet the following criteria:**

- If you are covered by an approved sponsorship agency/embassy.
- If your Spouse's Employer's medical insurance includes the basic benefits - see attached International Students Basic Benefits Form.
- If you are a continuing international student who was granted a waiver for the 2004-05 -The Documentation of continued coverage by the same alternate carrier must be received by Student Health Services no later than September 1st - see attached International Student Medical Insurance Waiver Form

**Student Name**

\_\_\_\_\_ (Family name) (First/given)

UM ID # \_\_\_\_\_ Telephone # \_\_\_\_\_

**INSTRUCTIONS TO INSURANCE COMPANY:** Please complete the form on page 1 and 2. Incomplete forms will not be accepted. Return both pages to the above address.

Insurance Co. Name \_\_\_\_\_

Policy # \_\_\_\_\_ Dates of coverage \_\_\_\_\_ / \_\_\_\_\_  
(Beginning) (Ending)

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

U.S. Claims Agent Phone Number ( \_\_\_\_\_ )

Rule 6C-6.009(6) provides that **“no foreign student in F-1, F-2, J-1, J-2 non-immigrant status shall be permitted to register or to continue enrollment at a (state) university (in Florida) without demonstrating that he or she has adequate medical insurance coverage for illness or accidental injury”**

Name \_\_\_\_\_  
(Last/Family) (First/Given)

**The insurance policy must include the following basic benefits. Please state YES or NO for each item listed, for any item answered NO please describe your company's coverage. Please attach a copy of the insurance policy brochure (in English) being considered for waiver to this form.**

- \_\_\_ 1. Coverage period: 52 continuous weeks or the complete time insured will be attending University of Miami;
- \_\_\_ 2. Aggregate cap: at least \$250,000 per illness or injury;
- \_\_\_ 3. Deductible: should not exceed \$100 per illness or injury;
- \_\_\_ 4. Basic benefits: Room, Board, hospital services, physician fees, ambulance, outpatient services fees paid at 80% of first \$5,000 of usual, customary, reasonable (UCR) fees after deductible is met; from \$5,000 to \$250,000 per illness/injury paid at 100% of UCR;
- \_\_\_ 5. Inpatient and/or outpatient mental health care; 80% of first \$5,000 of UCR up to a total of 30 days per policy year after deductible is met; from \$5,000 to \$250,000 paid at 100% of UCR;
- \_\_\_ 6. Maternity benefits; treated as any other basic benefits;
- \_\_\_ 7. Inpatient/outpatient prescription medications; offers coverage;
- \_\_\_ 8. Must cover HIV/AIDS and sexually transmitted diseases;
- \_\_\_ 9. Must cover substance/alcohol rehabilitation treatment;
- \_\_\_ 10. Repatriation: \$10,000 (coverage to return remains to home country);
- \_\_\_ 11. Medical Evacuation; \$25,000 (if directed by the physician in charge to be medically necessary, the expenses of the patient to be transported back to his home country by and accompanied by an escort);
- \_\_\_ 12. Exclusion for pre-existing conditions: should not exceed 6 consecutive months;
- \_\_\_ 13. Claims agent in the United States;
- \_\_\_ 14. Claims payable in United States dollars;
- \_\_\_ 15. This insurance company is licensed to do business in the State of Florida.

**The insurance policy shall not exclude any activities inherent to the student's academic career.**

**TO THE INSURANCE COMPANY REPRESENTATIVE:** Please read and sign the following. **I have verified the information on this form and completed each item above. I am asserting that this company will pay their claims in U.S. funds. If the above noted policy is terminated, I will notify University of Miami immediately. I certify that the coverage indicated is now in force.**

Name (Print) \_\_\_\_\_ Title/Position \_\_\_\_\_

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

Telephone number \_\_\_\_\_

**FOR UNIVERSITY OF MIAMI OFFICE USE ONLY**

\_\_\_ Approved      \_\_\_ Denied      because: \_\_\_ #'s \_\_\_\_\_

\_\_\_ Subject to: Reason: \_\_\_\_\_

\_\_\_ Medical evac/repatriation: \_\_\_\_\_

\_\_\_ Prepay of premium \_\_\_\_\_

for \_\_\_ month(s) \_\_\_\_\_

Authorized Signature \_\_\_\_\_ - Date \_\_\_\_\_