



UNIVERSITY OF
SOUTH FLORIDA

Student Health Services-International Student Health Insurance Compliance Form

4202 E. Fowler Ave, SHS 100 • Tampa, FL 33620-6750 • Phone: (813) 974-5407 • Fax: (813) 974-8910 • e-mail: insurance@shs.usf.edu

THIS SECTION IS TO BE COMPLETED BY THE INTERNATIONAL STUDENT

Student ID Number: U -

Last /Family Name First/Given Name

Street Address

City State Zip Code

Phone Number Date of Birth

Subscriber/Insurance ID Number Group Number

This form is designed to assist international students in complying with Florida Administrative Code Rule 6C-6.009(6) and USF Rule 6C4-6.0162. All non-United States Citizens or non-United States Permanent Residents shall only be permitted to register or continue enrollment at USF by demonstrating that he or she has medical coverage for illness or accidental injury. International students will automatically be enrolled under the USF Health Insurance Policy unless he or she submits proof (by the 5th day of the term) of coverage under an alternate health insurance policy. International students in F-1, F-2, J-1 or J-2 visa classes including special, non-degree seeking students, must demonstrate that they have adequate insurance coverage with benefits at least equal to those required by USF Rule 6C4-6.0162. **Only an alternate policy with an effective date of the 1st day of the term or prior will be considered. No exceptions will be granted.**

Please be advised that if an alternate insurance policy is not approved, it does not mean that USF, or any of its employees recommend the cancellation of any existing, pending or proposed insurance coverage. A denial only indicates that the policy presented does not meet the minimum established guidelines.

Instructions to the Student: Ask your insurance company representative to complete and return this form to the address or fax number listed above.

Release information: I hereby permit my insurance company to release the following information to the USF Student Health Services.

Student Signature **Date**

FOR OFFICE USE ONLY:

Approved: YES NO

Comments:

SHS/SIO (authorized signature):

Date: Expiration Date:

THIS SECTION IS TO BE COMPLETED BY THE INSURANCE COMPANY

Insurance Company Name Phone Number

U.S. Claims Agent Address

Please answer ALL questions.

- Effective Date: Termination Date:
- Aggregate Lifetime Max \$
- Deductible \$
- Is there a pre-existing clause? Yes No If yes, please give length of time pre-existing would apply
- Inpatient benefits are paid at %
- Outpatient benefits are paid at %
- Inpatient mental health benefits are paid at % (# of days allowed annually)
- Outpatient mental health benefits are paid at %
- Maternity benefits are paid at %
- Are there prescription benefits for Inpatient Outpatient ?
- Is Medical Evacuation coverage a benefit? Yes No \$ (To permit escort to accompany patient to home country, if directed by physician)
- Is Repatriation coverage a benefit? Yes No \$ (In the event of death, to return remains to home country)

Comments:

To the Insurance Company Representative: Please read and sign the following: *I have verified that the information that is provided on this form is valid. I am asserting that the coverage indicated is currently effective and claims will be paid in U.S. funds.*

Print Name Position

Signature Date

Telephone Fax