SEMINOLE STATE COLLEGE

ALTERNATE INSURANCE COMPLIANCE FORM FOR INTERNATIONAL STUDENTS

2022-2023 Academic Year

Insurance Requirement for International Students

All international students are permitted to enroll in classes at Seminole State College only after demonstrating that they hold medical insurance coverage which meets the school's requirements. International students may either purchase the Sickness & Injury program designed specifically for Seminole State College international students through Wellfleet Insurance Company or provide proof of an acceptable alternate medical insurance plan.

The following types of plans are not accepted:

- Plans from insurance companies located outside of the United States
- Travel Insurance or Short-term in-bound insurance policies
- Reimbursement Plans
- Plans that do not provide benefits equivalent to US Federal Health Care Reform Law coverage requirements
- Any plan that does not **FULLY** meet each of the 15 benefit requirements on this waiver form

Students must complete Section I below with their information and have their insurance carrier complete Section II. Completed forms must be submitted to Insurance for Students, Inc. along with the policy Schedule of Benefits by August 31, 2022. **NO EXCEPTIONS. Compliance forms missing any of the above will be immediately rejected.**

SECTION I: TO BE COMPLETED BY THE STUDENT

Name:_____ Student ID# _____
Last/Family/Surname First/Given Middle

Date of Birth: _____ Gender: M___F____ Immigration Status: F-1__ J-1 __ J Other (explain): _____
Month/Day/Year

Address:_____
Street/Apartment # City State Zip Code/Country

Contact Information:_____
Telephone # Cell Phone# Email Address

Policy Information: _____
Insurance Company Name Policy/Group Number

Student Acknowledgment and Release: I understand the international student insurance requirements for Seminole State College 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.

A denial implies only that the policy presented does not meet the minimum criteria established by Seminole State College 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.

_____ _____
Student's Signature Date

SECTION II: TO BE COMPLETED BY THE INSURANCE COMPANY

Return completed form and a copy of the policy Schedule of Benefits to:

Insurance For Students, Inc. 1690 S. Congress Avenue, Suite 101 Delray Beach FL 33445 USA
Phone: 800-356-1235, Fax 954-772-0872, Email: seminolestate@insuranceforstudents.com

State YES or NO for each of the coverage requirements listed and indicate which page number of the accompanying schedule of benefits the benefit is indicated.

_____ 1. Coverage Period*: Policy must be in force, paid FULLY in advance & non-cancellable from August 15, 2022 to August 14, 2023. **NOTE:** For students beginning enrollment at Seminole State College in the Spring or Summer terms, coverage must extend from at least the beginning of the term to August 14, 2023.

_____ 2. Basic Benefits: Room & board, hospital services, physician & surgeon fees and outpatient services paid at 80% or more of PPO Allowance per injury or sickness with no maximum benefit limit and 60% or more of Usual & Customary charges for out-of-network providers per injury or sickness. **PAGE NUMBER** _____

_____ 3. Out-of-pocket expenses: Plan must have a preferred provider out of pocket maximum of no more than $8,500 per policy year with no internal benefit period limitations. **PAGE NUMBER** _____

_____ 4. Inpatient & Outpatient Mental Health Care: Paid at 80% PPO Allowance in-network or 60% out-of-network of Usual and Customary fees with no benefit limitations & includes coverage for Drug & Alcohol Substance Abuse. **PAGE NUMBER** _____

_____ 5. Maternity Benefits: Treated as any other temporary medical condition and paid at no less than 80% PPO Allowance in network or 60% out-of-network of Usual and Customary fees. **PAGE NUMBER** _____

_____ 6. Prescription Medication: Policy must provide pharmacy copays with no maximum policy limit. **PAGE NUMBER** _____

_____ 7. Pre-Existing Conditions: Policy must provide coverage, unconditionally, for pre-existing-conditions. **PAGE NUMBER** _____

_____ 8. Policy is filed and approved in the United States and fully compliant with the Affordable Care Act benefit regulations.

PAGE NUMBER _____

_____ 9. Deductible: $250 per year maximum. **PAGE NUMBER** _____

_____10. Minimum coverage: Unlimited maximum benefit for covered injuries & sickness per policy year. **PAGE NUMBER** _____

_____11. Insurance Carrier must have a rating of either "A -" or above by A.M. Best or "A -" or above by Standard & Poor's Claims-paying Ability

_____ 12. Claims: The alternate policy has a claims agent located in the United States. **PAGE NUMBER** _____

_____13. Policy provisions must be in English and Claims must be paid in U.S. dollars. **PAGE NUMBER** _____

_____14. Repatriation: $50,000 or more (coverage to return the student's remains to his/her native country). **PAGE NUMBER** _____

_____15. Medical Evacuation: $100,000 or more (permits the patient to be transported to his/her home country and to be accompanied by a provider or escort if directed by the physician in charge). **PAGE NUMBER** _____

Acknowledgment: Policy # _____ issued by (company name) _____to

(student's name) _____for the period from _____ to _____.
Month/Day/Year Month/Day/Year

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 Seminole State College is relying on these representations in permitting this student to register or continue enrollment. If the above policy is terminated for any reason, I will notify Insurance For Students, Inc. immediately at the contact information above.

Company Representative: _____
Name Position

Insurance Agency: _____

U.S. Claims Agent Address:_____

U.S. Claims Agent Contact: _____
Telephone Fax Email

Insurance Agent Signature:_____Date:_____