



**OFFICE OF INTERNATIONAL
ADMISSIONS AND RECRUITMENT**

**INTERNATIONAL STUDENT
HEALTH INSURANCE COMPLIANCE FORM**

This form has been designed to assist international students in complying with the College's rule requiring all international students to have a health and accident insurance in order to register or enroll. If you wish to purchase an alternate policy, you must provide proof that your proposed policy provides benefits at least equal to those required by PBCC.

INSTRUCTIONS TO STUDENTS: Please ask your insurance company to complete this form and return it to:

**Office of International Admissions and Recruitment
Palm Beach Community College
4200 South Congress Avenue
Lake Worth, FL 33461
Tel: (561) 868-3029 Fax: (561) 868-3623**

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 PBCC.

Release Information: I hereby permit my insurance company to release the following information to staff persons at Florida International University. Also, I understand the international insurance requirements established by PBCC 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 reviewed at the end of the approval period indicated below.

I understand that, if alternate insurance is not approved, this does not mean that PBCC 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 PBCC with respect to specific medical insurance coverage criteria for registration and/or enrollment.

Print Name: _____ **PBCC Student ID #:** ____ - ____ - ____

Signature: _____ **Date** _____

INSTRUCTIONS TO INSURANCE COMPANY: Please complete the form on page 1 and 2. Indicate the insured's name and student ID number, the insurance company name, U.S. claims agent/address/phone, policy number, and dates of commencement and termination of coverage. For items 1-12 state "YES" for every benefit covered or exceeded in the insured's policy and "NO" for benefits not covered or that do not meet the stated amounts of coverage. Please print your name and title and then sign and date the form on page 2.

Student Name: _____

Insurance Co. Name: _____

Policy #: _____ **Dates of Coverage (Beginning - Ending)** _____

U. S. Claims Agent Name: _____

U. S. Claims Agent Address: _____

U. S. Claims Agent Phone: (____) _____ **Fax Number** (____) _____

PLEASE NOTE: The insurance policy must include the following basic benefits. Please state YES (meets minimum requirements) or NO (does not meet) for each item listed:

- _____ 1. Coverage is pre-paid and continuous for a minimum of twelve months from _____ to _____ or nine months from _____ to _____.
- _____ 2. Coverage is not restricted to a specific health care provider. Use of the policy is not restricted to a particular geographical area.
- _____ 3. The policy provides for coverage of major medical expenses at a minimum of 80% of usual, reasonable, and customary charges without specific limits on charges such as hospital room and board, hospital miscellaneous, physician visits, surgery, anesthesia, etc., up to a maximum of \$250,000 per accident/illness.
- _____ 4. Exclusion for pre-existing conditions- not more than first six months.
- _____ 5. Deductible is not greater than \$100 per accident /illness and per person.
- _____ 6. Inpatient mental health care paid at a minimum of 50% of the usual and customary fees with a 30-day cap.
- _____ 7. Outpatient mental health care paid up to \$1000 per year.
- _____ 8. Maternity benefits treated as any other temporary medical condition.
- _____ 9. Inpatient/Outpatient Prescription Medication: Offers coverage.
- _____ 10. The policy provides a maximum of \$25,000 for repatriation of remains to the home country.
- _____ 11. The policy provides a maximum of \$50,000 for medical evacuation to the home country, including expenses associated with an attendant, when medically necessary.

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

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 certify that the coverage indicated is now in force. If the above note d policy is terminated, I will notify Palm Beach Community College, Office of International Admissions and Recruitment.*

Name: _____ **Title:** _____

Signature: _____ **Date:** _____

Telephone: _____ **Fax:** _____

_____ **FOR PBCC OFFICE USE ONLY** _____

_____ **Approved until:** _____

_____ **Denied** _____ **Reason(s):** _____

OIAR Authorized Signature

Date