INTERNATIONAL STUDENTS
MEDICAL INSURANCE COMPLIANCE FORM
FOR F1, F2, & J1, J2 STUDENT VISA HOLDERS
STATE OF FLORIDA REQUIREMENTS

HEALTH INFORMATION MANAGEMENT AND COMPLIANCE
UCF Student Health Services
studenthealth.ucf.edu
Phone: (407) 823-6295

THIS SECTION IS TO BE COMPLETED BY THE STUDENT

Social Security Number

or UCF ID (PID)

Last/Family Name _____ First Name _____

Street Address _____

City _____ State _____ Zip Code _____

Phone Number _____ Date of Birth _____

Board of Governors Regulation 6.009 Admission of International Students to State University System Institutions, Section 2.
No international student in F or J non-immigrant statusshall be permitted to register, or to continue enrollment, at a university without demonstrating that the student, and in the case of J visa holders, that their accompanying spouse and dependents have adequate medical insurance coverage for illness or accidental injury which includes the following minimum requirements. (Items 1- 13)

INSTRUCTIONS FOR STUDENTS:
In order to be considered properly insured, have this form completed by the health insurance company and upload it via the online submission system available on the Student Health Services website. If your policy does not meet these requirements, you may consider options, including the UCF Student Health Insurance Plan by Gallagher Student Health and Special Risk. For details, go to https://www.gallagherstudent.com/ucf.

Student's Signature _____ **Date** _____

*** A copy of the certificate of coverage must be provided with this form.**

THIS SECTION IS TO BE COMPLETED BY THE INSURANCE COMPANY

Insurance Company Name _____ Policy Number _____ Coverage Dates _____

U.S. Claims Agent Address _____ Phone _____

State of Florida Requirements:

1. Coverage Period: Policies must provide, at a minimum, continuous coverage for the entire period the insured is enrolled as an eligible student, including annual breaks during that period. Payment of benefits must be renewable.
2. Basic Benefits: Room, board, hospital services, physician fees, surgeon fees, ambulance, outpatient services, and outpatient customary fees must be 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.
3. Inpatient Mental Health Care: Must be paid at 80% in-network or 60% out-of-network of the usual and customary fees with a minimum 30-day cap per benefit period.
4. Outpatient Mental Health Care: Must be paid at 80% in-network or 60% out-of-network of the usual and customary fees for a minimum of 30 (preferably 40) sessions per year.
5. Maternity Benefits: Must be treated as any other temporary medical condition and paid at no less than 80% of usual and customary fees in-network or 60% out-of-network.
6. Repatriation: $25,000 (coverage to return the student's remains to his/her native country).
7. Medical Evacuation: $50,000 (to permit 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).
8. Deductible: Maximum of $50 per occurrence if treatment or services are rendered at the Student Health Center; maximum of $100 per occurrence if treatment or services are rendered at an off-campus ambulatory care or hospital emergency department facility.
9. Minimum coverage: $100,000 for covered injuries/illnesses per policy year.
10. Insurance Carrier must be, at a minimum, (an A rating or above) to meet the rating requirements specified in Part 62.14(c)(1) of Title 22 of the Code of Federal Regulations.
11. Policy must not unreasonably exclude coverage for perils inherent to the student's program of study.
12. Claims must be paid in U.S. dollars payable on a U.S. financial institution.
13. Policy provisions must be available from the insurer in English.

Authority: Section 7(d), Art. IX, Fla. Const., History--Adopted 7-6-72, 12-17-74, Amended 6-21-83, 8-11-85, Formerly 6C-6.09, Amended 12-9-91, 9-27-07, Amended and Renumbered 1-29-09, Amended 6-23-16.

To the Insurance Company Representative: Please sign and stamp: *I attest to the fact that this insurance policy covers the above basic benefits. I have completed and verified the information on this form and Include a copy of the insured's insurance card.*

Insurance Representative Name & Position (Print) _____

Insurance Representative Signature _____ **Date** _____

Insurance Stamp