METHODIST UNIVERSITY

International Student Health Insurance Compliance Form

Student Insurance office•5400 Ramsey Street•Fayetteville, NC 28311•(910)630-7652
Fax or e-mail completed form to (910)630-7544 or dkuch@methodist.edu

Student ID Number: _____

_____

Last Name First Name

_____

Date of Birth Home Country

Street Address State Zip Code

Insurance ID Number Group Number

This form is designed to assist international students in complying with Methodist University regulation that all non-United States Citizens or non-United States Permanent Residents shall only be permitted to register or continue enrollment at Methodist University by demonstrating that he or she has medical coverage for illness and accidental injury.

International students are automatically enrolled under Methodist University insurance policy unless proof is submitted of coverage under an alternate health insurance policy prior to the 1st day of the term. 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 Methodist University.

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

Only an alternate policy with the effective date of the 1st day of the term or prior will be accepted. All students must provide proof of continuous coverage until the end of the academic year regardless of the student's terms of enrollment. Insurance Company must have a home base address and phone number in the U.S.

Students Signature Date

For Office Use Only: Approved? Yes ____No_____
Comments:_____

_____
Student Health Coordinator Date

This section is to be completed by the insurance Company

Travel insurance plans requiring reimbursement of medical services does not meet the regulations.

Effective Fall 2016, an adequate health insurance policy must contain these elements:

1.) Basic benefits: Inpatient and Outpatient services paid at 80% of usual, customary and reasonable (UCR) charge after deductible is met for in-network providers, and 70% or more or (UCR) charge for out-of-network providers per accident or illness.
2.) Inpatient mental health care: paid at 80% in-network or 60% out-of-network of (UCR) charge with a minimum 30 day cap per benefit period.
3.) Outpatient mental health care: paid at 80% in-network or 60% out-of-network of (UCR) charge for a minimum of 30 sessions per year.
4.) Maternity benefits: treated as any other temporary medical condition and paid at no less than 80% of (UCR) in- network or 60% out-of-network.
5.) Inpatient/outpatient prescription benefit: minimum coverage $1,000 per policy year,
6.) Pre-existing conditions: exclusion period must not exceed six months.
7.) Deductible: Maximum of $100 per occurrence if treatment or services are rendered at an off- campus ambulatory care or hospital emergency department facility: not to exceed $500 per policy year.
8.) Minimum coverage: $250,000 for coverage injuries/illness per policy year.
9.) Insurance carrier must have an "A" rating or above per Part 62.14 (c)(1) of section 22 of the Code of Federal Regulations:
10.) Policy must not unreasonably exclude coverage for perils inherent to the student program of study.
11.) Claims must be paid in U.S. dollars payable on a U.S. financial institution; and
12.) Policy provisions must be available from the insurer in English.
13.) Repatriation of Moral Remains: F-1/ F-2, J-2 and J-1 visa min. $10,000
14.) Medical Evacuation: F-1/F-2, J-1 and J-2 visa min $100,000 including coverage for an accompanying provider or escort, if directed by the physician in charge.

Does Policy #_____Issued by_____:
to _____meet the minimum requirements as stated above for the period from__/___/____ to___/___/___
Yes___No____Comments:_____

_____
Print Representative Name (Required) Position

_____
Signature of Representative (required) Date

_____ _____
U.S. Insurance Company Name U.S Phone Number