

**Virginia Tech
Student Medical Insurance Office**

ALTERNATIVE INSURANCE COMPLIANCE FORM

This form is designed to assist international students in complying with Virginia Tech's rules requiring all international students to have health insurance in order to register or enroll at Virginia Tech. Virginia Tech makes available a policy that provides excellent coverage. If you wish to purchase an alternate policy, you must document that your proposed policy provides benefits that meet certain requirements.

INSTRUCTIONS TO STUDENTS: Please ask your insurance company to complete this form and return it to: **Student Medical Insurance Office, Virginia Tech, Mail Code 0361, Blacksburg, Virginia, 24061. U.S.A. FAX (540) 231-6237/ Phone (540) 231-6226.** The insurance company must verify that the basic benefits listed below are included in your health insurance policy; if any of those benefits are not covered, we cannot remove your block to register for classes or continue enrollment at Virginia Tech. Please allow sufficient time for processing this form.

RELEASE INFORMATION: I hereby permit my insurance company to release the following information to staff at Virginia Tech. Also, I understand the international insurance requirements established by Virginia Tech and agree to abide by them. I understand that alternate insurance policies are approved for limited periods and that requirements for alternate policy coverage are subject to change. I further understand that I must have my policy **re-certified annually, prior to each fall term registration.**

I understand that, if alternate insurance is not approved, this does not mean that Virginia Tech 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 Virginia Tech with respect to specific medical insurance criteria, listed on page 2, required for registration and/or enrollment.

Print Name _____ Signature _____ Date _____
Student ID Number _____ Local Phone # _____
Email Address _____

INSTRUCTIONS TO INSURANCE COMPANY: Please complete the form below. For items 1-12, state "YES" (the insured's policy meets or exceeds the minimum benefit listed) or "No" (for benefits not covered or that do not meet the stated minimum amounts of coverage required). Please provide the requested information shown below, then sign, **date and have notarized (or appropriate foreign verification)** the form on page 2.

STUDENT NAME (last/family) _____ (first/given) _____
STUDENT ID NUMBER _____
INSURANCE COMPANY NAME _____
POLICY NUMBER _____
DATES OF COVERAGE (beginning) _____ (ending) _____
CLAIMS AGENT ADDRESS _____
CLAIMS AGENT PHONE NUMBER _____

International students are not permitted to register or to continue enrollment at Virginia Tech without demonstrating compliance with the insurance requirement. The University is unable to make any exceptions to this rule.

FOR INSURANCE COMPANY COMPLETION - ALL ITEMS, 1 THROUGH 12, MUST BE MET IN ORDER TO QUALIFY AS ALTERNATIVE INSURANCE.

Please state "YES" (YES- MEETS or EXCEEDS minimum requirements) or "NO" for each item listed:

- ___ 1. If a Preferred Provider (PPO) network is provided, the PPO must offer adequate provider coverage within a 50 mile radius of Blacksburg.
- ___ 2. Deductibles should be no more than \$200. While it is recommended the deductible be per insured per year with a maximum of \$400 per family in total deductibles paid per year, it is acceptable to have no more than a \$200 deductible per illness or injury per insured, with no cap on the maximum deductible paid out.
- ___ 3. Major Medical benefits of at least \$50,000 per insured per policy year or major medical benefits of at least \$200,000 maximum benefit per insured per accident or illness. This includes dependent coverage as well.
- ___ 4. Exclusions for **pre-existing conditions may be no more restrictive than the following:**
Pre existing means:
(1) a condition that manifests itself during the six month period immediately preceding the covered person's effective date under the policy, or (2) for which medical advice, diagnosis, care or treatment was recommended or received within six months immediately prior to the covered person's effective date under the policy. A pre-existing condition will be covered under the Plan once an insured has been continuously insured under the Plan for at least 12 consecutive months.
- ___ 5. **Inpatient mental health care** paid at least 80% for the usual and customary fees with a 25 day cap.
- ___ 6. **Outpatient mental health** – Minimum of 20 visits. 80% for visits 1-5, 50% for visits 6-20.
- ___ 7. Maternity benefits treated as any other illness under the plan.
- ___ 8. Inpatient/Outpatient **Prescription Medication**. Offers coverage (after co pays) with a minimum of \$1,000 per insured per policy year.
- ___ 9. The policy provides a **minimum of \$10,000** for "**repatriation of remains**" or "**medical evacuation**" to the home country.
- ___ 10. There should be no pre-existing condition requirement, which excludes coverage permanently under the policy.
- ___ 11. Benefits paid to a student or dependent under any plan prior to the student's initial policy effective date cannot be counted against the maximum benefit payable under the policy.

IF ITEM 1 THROUGH 11 ARE MET, ITEM 12 MUST ALSO BE MET IN ORDER FOR THE POLICY TO QUALIFY AS SATISFACTORY ALTERNATIVE INSURANCE.

- ___ 12. Coverage is **prepaid** and continuous for a **minimum of SIX months** and effective through the following July 31. Coverage taken after February 1 must be prepaid and continuous through the following July 31.

Comments: Please comment about the policy coverage and any of the above items.

INSURANCE COMPANY REPRESENTATIVE: (Please read and sign). 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 noted policy is terminated, I will notify the Student Medical Insurance at Virginia Tech, immediately, telephone 540-231-6303.**

Print Name _____ Title _____
 Signature _____ Date _____
 Telephone _____ Fax _____

Notary: Signed before me on this Date: _____
 Date Signature

(Expiration information and Notary Seal)

For Student Medical Insurance Office Use: Approval Signature _____
 Date of Approval _____ Date of Expiration _____