Rollins College

International Student Health Insurance Waiver

This form has been prepared to assist international students in complying with the Rollins College policy requiring international students to have health insurance in order to register or enroll at Rollins College. No foreign student in F-1, F-2, J-1, or J-2 non-immigrant status shall be permitted to register or to continue enrollment at Rollins College without demonstrating that he or she has adequate medical insurance coverage for illness or accidental injury. Rollins College makes available a policy that meets and exceeds the minimum standards of required coverage. 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 Rollins College. This Compliance Form should be used to provide this information to staff at the Bursar's office.

Instructions to Student: Ask your insurance company representative to complete this form and return it to Rollins College, Office of the Bursar, 1000 Holt Avenue – 2716, Winter Park, FL 32789 or via fax to (407) 975-6497. If your representative has any questions regarding this form, please call 800-922-3420.

Release Information: I hereby permit my insurance company to release the following information to staff persons at Rollins College. Also, I understand the International insurance requirements established by Rollins College and agree to abide by them. I understand that alternate insurance policies are approved for limited periods not exceeding one year and that requirement 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 Rollins College, or any of its employees, recommend that I cancel my existing, pending or proposed insurance coverage. A denial implies only that the policy presented does not meet the minimum criteria established by Federal guidelines with respect to specific medical insurance coverage criteria required for registration and/or enrollment.

Student Signature: ____ Date: ____________________________

Instructions to Insurance Company: Please complete the form below. Indicate the insured's name and social security number, the insurance company name, U.S. claims agent/address/phone, policy number and dates of commencement and termination of coverage.

Student Name: (Last/Family) _____________________________ (First) ______________________________
Social Security Number: __________ _______ ____________

Insurance Company Name: ____
Date Coverage Begins: _____________________________ Terminates: ______________________________

U.S. Claims Agent Address: ____
U.S. Claims Agent Phone#: ____

The insurance policy must include the following basic benefits. Please state YES or NO for each item listed.

1. _______Coverage period: 52 continuous weeks
2. _______Basic Benefits: Room, board, hospital services, physician fees, surgeon fees, ambulance, outpatient services and outpatient fees paid at 80% of usual, customary, reasonable (UCR) fees after deductible is met
3. _______Inpatient mental health care: 50% of the Usual and customary fees with a $100 cap
4. _______Outpatient mental health care: Paid at 50% of the usual and customary fees with a $100 cap
5. _______Maternity benefits: Treated as any other temporary medical condition
6. _______Inpatient/Outpatient prescription medication: Offers coverage
7. _______Repatriation: $7,500 (coverage to return remains to the home country)
8. _______Medical evacuation: $10,000 (to permit the patient to be accompanied by an escort if directed by the Physician in charge).
9. _______Exclusion for pre-existing conditions: First twelve (12) months
10. _______Deductible: $0 deductible
11. _______Aggregate Cap: $50,000 for covered injuries/illnesses per individual Student
12. _______Claims Agent in the United States

I have verified the information on this form and completed each item above. I am asserting that this company will pay their claims in U.S. funds. If the above noted policy is terminated, I will notify Rollins College immediately. I certify that the coverage indicated is now in force.

Print Name: _______________________________________ Position: _____________________________
Signature: _______________________________________ Date: _____________________________
Telephone #: _______________________________________ Fax #: _____________________________

Rollins College Approval (Authorized Signature): ____

Date of Approval: __________________________ Date of Expiration: ______________________________

Form must be returned to the Office of the Bursar no later than 7/31/08. If the completed form is not received by this date the studentwill automatically be enrolled in the Rollins Student Health Insurance Plan and will be responsible for the premium fee.