TSC | INTERNATIONAL STUDENT SERVICES

444 Appleyard Drive
Tallahassee, Florida 32304
(850) 201-8258
iss@tsc.fl.edu

F-1 Students – Alternative Health Insurance Compliance Form

All F-1 international students are required to have valid health insurance for the duration of their studies at Tallahassee State College.

Students are permitted to enroll in classes at TSC after demonstrating that they hold valid health insurance, which meets all of the requirements listed below. Any health insurance plan that does not fully meet each of the requirements listed below will not be accepted.

International students may either purchase the Sickness & Injury program designed specifically for TSC international students or provide proof of an acceptable alternate medical insurance plan. The following types of plans are not accepted:

- Travel Insurance
- Short-term in-bound insurance policies
- Reimbursement Plans
- Any plan that does not FULLY meet each of the 16 benefit requirements on this compliance form

Students must complete Section I below with their information and have their insurance carrier complete Section II. Completed forms must be submitted to Insurance for Students, Inc. along with the policy Schedule of Benefits by ***1 week before the I-20 Program Start Date (for Initial and Transfer F-1) or 1 week before the First Day of classes (For Continuing F-1)***. Compliance forms missing any of the above will be immediately rejected.

SECTION I: TO BE COMPLETED BY THE STUDENT

Full Name: _____
(Given) *(Middle)* *(Last)*

TSC Student ID: _____ **SEVIS ID Number**: _____

Date of Birth: _____ **Gender**: M ____ F ____
(*mm/dd/yyyy*)

E-mail Address: _____ **Phone Number**: _____

Policy Information: _____
Insurance Company Name Policy/Group Number

Student Acknowledgement: I understand the international student insurance requirements for Tallahassee State College and I agree to abide by them. I understand that alternate insurance policies are approved for periods not exceeding one year at a time, and requirements are subject to change. A denial implies only that the policy presented does not meet the minimum criteria established by Tallahassee State College with respect to specific medical insurance coverage criteria required for registration and/or enrollment. Furthermore, I understand that I must have my policy recertified annually.

_____ _____
Student's Signature Date

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SECTION II: TO BE COMPLETED BY THE INSURANCE COMPANY

State YES or NO for each of the coverage requirements listed and indicate which page number of the accompanying schedule of benefits the benefit is indicated.

_____ 1. Coverage Period: Policy must be in force, paid FULLY in advance & non-cancellable from the I-20 Program Start Date (for Initial and Transfer F-1) or First Day of classes (For Continuing F-1) to one year (eg. August 16, 2024 to August 15, 2025). NOTE: For students beginning enrollment at Tallahassee State College in the Spring or Summer terms or for Continuing students in Fall 2024 whose old coverage ended in Fall term, new coverage must extend from at least the beginning of the Spring term to the end of the academic year.

_____ 2. Basic Benefits: Room & board, hospital services, physician & surgeon fees and outpatient services paid at 80% or more of PPO Allowance per injury or sickness and 60% or more of Usual & Customary charges for out-of-network providers per injury or sickness. PAGE NUMBER _____

_____ 3. Inpatient Mental Health: Inpatient mental health care must be paid at 80% in-network or 60% out-of-network of the usual and customary fees. PAGE NUMBER _____

_____ 4. Outpatient Mental Health: Outpatient mental health care must be paid at 80% in-network or 60% out-of-network of the usual and customary fees. PAGE NUMBER _____

_____ 5. Maternity: Maternity benefits must be treated as any other temporary medical condition and paid at no less than 80% in-network or 60% out-of-network of the usual and customary fees. PAGE NUMBER _____

_____ 6. Repatriation: $25,000 (coverage to return the student's remains to his/her native country). PAGE NUMBER _____

_____ 7. Medical Evacuation: $50,000 (permits 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). PAGE NUMBER _____

_____ 8. Deductible: $500 per year maximum. PAGE NUMBER _____

_____ 9. Minimum coverage: $500,000 Minimum medical benefits for each covered injury / sickness per policy year. PAGE NUMBER _____

_____10. Rating: Insurance Carrier must have a rating of either "A -" or above by A.M. Best or "A -" or above by Standard & Poor's Claims-paying Ability

_____ 11. Inherent Perils: Policy must not unreasonably exclude coverage for perils inherent to the student's program of study

_____12. Claim Payment: Claims must be paid in U.S. dollars payable on a U.S. financial institution. PAGE NUMBER _____

_____ 13. Language: Policy provisions must be in English. PAGE NUMBER _____

_____ 14. Prescription Medication: Policy must provide a minimum benefit of $3,000 for prescription medication. PAGE NUMBER _____

_____ 15. Pre-Existing Conditions: Exclusion for Pre-Existing Conditions: First six months of policy period at most with a maximum 6 month look-back period. PAGE NUMBER _____

_____ 16. Policy provides coverage for routine preventative services. PAGE NUMBER _____

Acknowledgement: Policy # _____ issued by (company name) _____

to (student's name) _____ for the period from _____ to _____.
(mm/dd/yy) *(mm/dd/yy)*

I certify that the information above is true and accurate and I have verified the information pertaining to each of the requirements listed above. I understand that Tallahassee State College is relying on these representations in permitting the student to register or continue enrollment at the College. If the above policy is terminated for any reason, I will notify Tallahassee State College immediately at the contact information below.

Company Representative: _____ _____
Name Position

Insurance Agency: _____

U.S. Claims Agent Address: _____

U.S. Claims Agent Contact: _____
Phone Fax E-mail Address

Insurance Agent Signature: _____ _____
Date

SECTION III: TO BE COMPLETED BY THE REVIEWER

_____ I reviewed the coverage for the above Alternative Insurance Documentation and Form, and I recommend an approval.

_____ I reviewed the coverage for the above Alternative Insurance Documentation and Form, and I do not recommend an approval based on the following comments:

_____

_____

_____

_____

Reviewer Name: _____ Reviewer Signature: _____ Date: _____

If this form is being filled out by PDF, please return completed form and a copy of the policy Schedule of Benefits to: Office of International Student Services at iss@tsc.fl.edu