

ALTERNATE HEALTH INSURANCE PETITION for F1 INTERNATIONAL STUDENTS

According to the California State University Executive Order 622, all F1 students must purchase and maintain adequate health insurance coverage during their period of enrollment at CSU Fullerton. In order to comply, an international student's health insurance policy must meet the criteria listed below.

To be eligible for a waiver of the CSU insurance coverage, I understand the following must be completed:

1. This petition must be submitted before the deadline indicated for the appropriate semester
2. Each criterion listed below must be met. If any one of the criteria is not met (even if 1 box is checked "NO"), the waiver will not be approved and you must purchase CSU's health insurance policy.
3. Payment of your Alternate Health Insurance must be for the entire semester, and not on a monthly basis. Submit proof of purchase.

Section 1: To be completed by F1 student

check one box only: **Fall** _____ **Deadline: June 1st** **Spring** _____ **Deadline: October 1st**

As an F1 international student of CSU Fullerton, I agree that I am responsible for ensuring that my alternate health insurance is in compliance with the health insurance regulations outlined below. I understand that it is my responsibility to maintain my F1 status and continue health insurance coverage for myself (and my dependents, if any) throughout my degree program at CSU Fullerton. I further understand that falsifying any information or document(s) related to health insurance coverage and/or verification will result in my classes being dropped and falling out of F-1 status.

By signing this petition, I verify that I have purchased an alternate health insurance policy that meets the CSU criteria listed below.

Student's Name	Student ID#	Phone Number
Student's Signature	Date	E-Mail Address

Section 2: To be completed by Alternate Health Insurance Provider/Administrator

Our health insurance policy meets the following CSU criteria:

- | | | |
|--------------------------|--------------------------|---|
| <u>YES</u> | <u>NO</u> | <i>(please check one box for each criteria)</i> |
| <input type="checkbox"/> | <input type="checkbox"/> | The policy is valid until at least the beginning of the next semester.
<i>Fall coverage dates: August 1 - February 1 Spring coverage dates: February 1 - August 1</i> |
| <input type="checkbox"/> | <input type="checkbox"/> | The medical benefit is at least US \$250,000 per condition. |
| <input type="checkbox"/> | <input type="checkbox"/> | Co-payment does not exceed 25%. |
| <input type="checkbox"/> | <input type="checkbox"/> | The repatriation benefit is at least USD \$7,500. |
| <input type="checkbox"/> | <input type="checkbox"/> | The medical evacuation benefit is at least USD \$10,000. |
| <input type="checkbox"/> | <input type="checkbox"/> | The annual maximum deductible does not exceed \$100 per condition per plan year. |
| <input type="checkbox"/> | <input type="checkbox"/> | The policy must be funded in the United States. |
| <input type="checkbox"/> | <input type="checkbox"/> | The policy must comply with Title 9 and/or the Civil Rights Restoration Act of 1987 (i.e., benefits for expenses incurred for pregnancy conditions must be provided in the same manner as for any other condition). |
| <input type="checkbox"/> | <input type="checkbox"/> | The policy must provide benefits for conditions that have not been treated in the six months immediately preceding continuous coverage, or have no greater than a six-month waiting period for conditions that have been treated within the six months immediately preceding continuous coverage. |

By signing this petition, I understand that I am providing accurate and truthful information.

Provider's/Administrator's Name	Phone Number	Email
Provider's/Administrator's Signature	Date	Stamp of Company Provider

IEE Use Only: *Approved* *Denied* *Advisor's Initial:* _____ *Date:* _____
Email sent: _____ *Email sent:* _____