

**Virginia Tech International Student Medical Insurance
Fall Waiver 2017-2018
Deadline: September 14, 2017**

Return to: Student Medical Insurance, 110 Student Services Building, Blacksburg, VA, 24061
FAX: 540-231-6237/ Phone 540-231-6226/E-mail smi@vt.edu

Student Information			
Student Name: (Last/Family)		(First/Given)	
VT Student ID #:		E-Mail Address:	
Are you a J-1 Visa holder?	Yes or No	Are you a one semester student?	Yes or No
Do you plan on graduating this academic year?	Yes or No	If yes, when?	(Date)

One Semester Exchange Student Verification	
Immigration Advisor Signature:	Date:

Insurance Company Information / Completion			
Student Release: I hereby permit my insurance company to release the following information to staff at Virginia Tech or their designate. Student Signature: _____			
Insurance Company Name:		Policy Number:	
Dates of Coverage:	Beginning Date:	Ending Date:	

ALL CRITERIA MUST BE MET IN ORDER TO QUALIFY AS ALTERNATIVE INSURANCE Please indicate either YES / TRUE (Meets or Exceeds Minimum Stated Requirements) or NO / FALSE		
CRITERIA	YES/TRUE	NO/FALSE
Does the policy offer adequate provider care within a 50 mile radius of the campus of enrollment?		
Does the policy have a deductible of \$500 per accident or illness or less?		
Does the policy have major medical benefits of at least \$500,000 per accident or illness?		
Does the policy provide a minimum of \$25,000 for repatriation of remains and \$50,000 medical evacuation to the home country?		
Are medical expenses for pregnancy, childbirth and complications of pregnancy treated as any other illness under the policy?		
Does the policy offer Prescription Medication coverage (after co-pays) with a minimum of \$500,000 per insured per policy year?		
Is coverage valid from either August 1, 2017 or the first day classes begin at Virginia Tech until July 31, 2018 or, if graduating, the last day of the month of the student's graduation?		
Does the policy cover Outpatient and Inpatient Mental Health Care as any other illness?		
This policy has no internal caps coverage, including services, treatment or surgery.		
This policy has no pre-existing condition waiting period.		

Insurance Company Representative	
By submitting this form I certify that the coverage indicated above is now in force.	
Print Name:	Title:
Signature:	Date:

Student Medical Insurance Office Use Only	
Approval Signature:	Date of Approval: