Virginia Tech Student Medical Insurance; smi@vt.edu

Verification of Health Insurance for F2 and J2 Dependents

YOU MUST INCLUDE A COPY OF YOUR CERTIFICATE OF COVERAGE FROM YOUR INSURANCE COMPANY WITH THIS WAIVER.

Student Information

Last Name: ______________________________________

First Name: ______________________________________

VT Hokie ID#: ____

Email Address: ______________________________

Are you a one semester student? YES or NO

Number of Dependents covered under this plan: _________________

Names of Dependents: _________________________________ ______________________________

Release: I hereby permit my insurance company to release the following information to staff at Virginia Tech or their designate.

Insurance Company Information/Completion

Insurance Company Name: ____

Policy Number:____________________________________

Beginning Date of Coverage: _________________________

Ending Date of Coverage:

ALL CRITERIA MUST BE MET IN ORDER TO QUALIFY AS ADEQUATE HEATH COVERAGE

Note to Insurance Company: Please circle either YES or NO below

Criteria

- Does the policy offer adequate provider care within a 50 mile radius of the campus of enrollment? **Yes No**
- Does the policy have a deductible of $500 per accident or illness or less? **Yes No**
- Does the policy have major medical benefits of at least $500,000 per accident or illness? **Yes No**
- Does the policy provide a minimum of $25,000 for repatriation of remains **and** $50,000 medical evacuation to the home country? **Yes No**
- Are medical expenses for pregnancy, childbirth and complications of pregnancy treated as any other illness under the policy? **Yes No**
- Does the policy offer Prescription Medication coverage (after co-pays) with a minimum of $500,000 per insured per policy year? **Yes No**
- Does the policy cover Outpatient and Inpatient Mental Health Care as any other illness? **Yes No**
- This policy **does not** have limits or internal dollar caps on coverage, including services, treatment or surgery. **Yes(True) No(False)**
- This policy **does not** have a pre-existing condition waiting period. **Yes(True) No(False)**

Insurance Company Representative

By Submitting this form, I certify that the coverage indicated is now in force.

Name and Title (Printed): _______________________________________

Signature: ____

Student Medical Insurance Office Use ONLY

Approval Signature: ____________________________ _ Date: