VMCVM Proof of Insurance 2019-2020

Deadline: September 10, 2019

Return to: Student Medical Insurance, Suite 110 Student Services Building, 800 Washington Street SW Blacksburg, VA, 24061 FAX: 540-231-6237/ Phone 540-231-6226/E-mail at smi@vt.edu

Student Information					
Student Name: (Last/Family)		(First/Given)			
VT Student ID #:		**E-Mail Address:**			
Are you an F or J Visa holder?	Yes or No	**Campus of Enrollment**			
Do you plan on graduating this academic year?	Yes or No	**If yes, when?**	(Date)		

Student Insurance Information			
Insurance Company Name:		**Policy Number:**	

ALL CRITERIA MUST BE MET IN ORDER TO QUALIFY AS ALTERNATIVE INSURANCE
Please indicate either YES (Meets or Exceeds Minimum Stated Requirements) or NO

CRITERIA	**YES**	**NO**
Does this policy have major medical benefits of at least $100,000 per insured per policy year?		
Are the policy deductibles less than $2,500 per illness or injury, per insured with no cap on the maximum deductible paid out?		
Is this policy free of exclusions of coverage for participation in, travel to, or practice in club sports, intramural or extramural sports? Only participation in intercollegiate sports may be excluded.		
Is this policy free of any pre-existing condition exclusions that would permanently exclude coverage under the policy? After meeting a satisfactory waiting period, all accidents or illnesses would be covered.		
Under this policy, the benefits paid to a student under any plan prior to the student's initial policy effective date are not counted against the maximum benefit payable.		
Is the accident and sickness insurance effective on the date the application and premium are received by the insurer with no qualification requirements and assuming premiums are paid as required, effective until the start of the next academic year?		

Student Acknowledgement

By signing, the student acknowledges the following: 1. The student has read the College's Insurance Requirement policy found on the Student Medical Insurance website; 2) the student has adequate health insurance in accordance with said policy and therefore elects to waive the University's Student health Insurance Plan for the stated academic period; 3) the student's current insurance coverage is effective for the entire selected academic period; and 4) the information provided herein is true and correct to the best of his/her knowledge.

Print Name:	
Signature:	**Date:**

VMRCVM Admissions and Student Services	
Approval Signature:	Date of Approval:

Student Medical Insurance Office Use Only	
Received Signature:	Date of Receipt:

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