

Virginia Tech Student Medical Insurance; smi@vt.edu

Verification of Health Insurance for Visiting Scholars

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 HEALTH 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: _____