



International Student Services
 CP-207
 Phone: (657) 278-2909
 Fax: (657) 278-7114

Alternate Health Insurance Petition Form

California State University Executive Order 622 requires that all visa students purchase and maintain adequate health insurance coverage during their period of enrollment at CSUF.
 In order to comply, your insurance policy must meet ALL criteria listed below.

Section 1: To be completed by F-1 student

As an F-1 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 F-1 status and continue health insurance coverage for myself (and my dependents, if any) while attending UEE classes 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.

To be eligible for a waiver of the CSU insurance coverage, I understand that each criterion listed below must be met (ie. a "Yes" is checked for every box). If any one of the criteria is not met (even if only 1 box is checked "No"), that means that the waiver will not be approved, and I must purchase CSU's health insurance policy.

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 must be valid during the entire length of the course of study. From _____ to _____. |
| <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	E-Mail
_____	_____	_____
Provider's/Administrator's Signature	Date	Company's Stamp

NOTE: Students without proper health insurance coverage will not be able to attend classes. **Petition Deadline: first day of school.**