

F-1 AND F-2 STUDENT INSURANCE COVERAGE EVALUATION FORM

This form must be submitted (may be faxed at 225-578-1413 or e-mailed to jgoodlo@lsu.edu) to I.S. by Thursday, February 2, 2012(absolute deadline date.)

NAME: \_\_\_\_\_ LSU-ID: 89-\_\_\_\_\_
Please Print (Last Name, First Name)

I certify that the above named individual and \_\_\_\_\_ dependents have insurance coverage for the period
\_\_\_\_\_ through \_\_\_\_\_, which meets or exceeds the following as well as all mandated
(mm/dd/yy) (mm/dd/yy)
benefits(coverage must be begin on or before January 17, 2012 and end on or after May 12, 2012 at a minimum for
Spring 2012 semester):

Explain if NO:

- Medical and accident coverage up to \$50,000 per accident or illness .YES NO \_\_\_\_\_
OR \$100,000 minimum aggregate

- Maximum deductible of \$500. For multiple party plans \$500 per person YES NO \_\_\_\_\_

- A U.S. representative physically located in the United States with a U.S. telephone YES NO \_\_\_\_\_
number/contact who acts on behalf of insurance company/insurance plans: verification and processing ability

- Policy must cover office visits for non-emergency and emergency visits (No emergency YES NO \_\_\_\_\_
care only policies will be accepted)

- Maternity visits must be paid as any other health condition. YES NO \_\_\_\_\_

- Minimum coverage of \$7,500 repatriation of remains to home country. YES NO \_\_\_\_\_
(pre-existing conditions related deaths must be covered; coverage must remain in force during entire stay in the U.S.)

- Minimum coverage of \$10,000 medical evacuation of the exchange visitor to home country. YES NO \_\_\_\_\_
(pre-existing conditions related illnesses must be covered; coverage must remain in force during entire stay in the U.S.)

\*Repatriation and medical evacuation coverage can be assessed separately for those students/dependents with policies lacking the
repatriation/ medical evacuation coverage requirements for \$8 per semester.

NAME OF INSURANCE COMPANY: \_\_\_\_\_

AGENT REPRESENTING INSURANCE COMPANY: \_\_\_\_\_

Please print name

Signature of Agent \_\_\_\_\_ Date: \_\_\_\_\_

Policy No. \_\_\_\_\_

Phone number in United States \_\_\_\_\_

Address in the United States \_\_\_\_\_

I have enrolled in the above insurance program and verify that the above is true and accurate. I will continue to maintain this
coverage and will notify your office of any changes and provide appropriate documents of any changes. I will provide
documentation of continuation of the required coverage upon expiration of the policy as stated above. Furthermore, I will
provide the ISO with a new F-1 Insurance Coverage Evaluation Form each and every semester, regardless of the insurance
coverage end dates stated on any previously submitted forms.

Signature of Student: \_\_\_\_\_ Date: \_\_\_\_\_

Any fraudulent or misrepresented information will result in an official student misconduct report to the LSU Dean of Students' Office and possible University
suspension. Upon such findings, Louisiana State University will have no responsibility (legal or financial) to any health issues that apply to and have been incurred by
me, including death. The ISO reserves the right to investigate the validity of private policy benefits in order to meet all listed requirements.