Please see Instructions at http://oiss.uno.edu/UNOinsurancereq2.cfm before completing the form

UNIVERSITY OF NEW ORLEANS
F-1 INSURANCE COVERAGE EVALUATION FORM—SPRING 2020

This form must be submitted to the Office of International Students and Scholars (may be e-mailed to oiss@uno.edu) by 4:30 p.m. on Thursday, January 23, 2020. No late requests will be accepted.

Please do not purchase an insurance plan that will cover you past the Summer 2020 term. The Insurance Coverage Evaluation Form will be updated with new requirements beginning Fall 2020 and your insurance provider or coverage may need to change accordingly at that time.

Last Name: _____ **First Name:** _____ **UNO ID NUMBER:** _____

I certify that the above named individual and _____ **dependents have insurance coverage for the period** _____ **through** _____ **that meets or exceeds the following requirements (coverage must begin on or before 01/13/2020 and end on or after 05/13/2020 at minimum for Spring 2020).**

- Medical or accident coverage up to $100,000 per accident or illness OR $200,000 minimum aggregate	**YES / NO**
- 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 number/contact who acts on behalf of insurance company/insurance plans: verification and processing ability.	**YES / NO**
- Policy must cover office visits for non-emergency and emergency visits. (No emergency care only policies will be accepted.)	**YES / NO**
- Maternity visits must be paid as any other health condition.	**YES / NO**
- Minimum coverage of $25,000 repatriation of mortal remains to home country. (Must cover pre-existing condition related deaths.)	**YES / NO**
- * Minimum coverage of $50,000 medical evacuation of the student to his/her home country.	**YES / N0**

*Repatriation and medical evacuation coverage can be purchased separately for those students/dependents whose policies lack this coverage. Students must submit proof of separate repatriation and evacuation coverage for the waiver to be approved.

NAME OF INSURANCE COMPANY (print) _____

AGENT REPRESENTING INSURANCE COMPANY (print) _____

Signature of Agent _____

Date _____ **Policy No.** _____

Phone number in United States _____

Insurance company address in 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 OISS 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 Office of International Students and Scholars 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(Required): _____ **Date:** _____

Any fraudulent or misrepresented information will result in an official student misconduct report to the UNOStudent Accountability and Advocacy Office. This referral could result in suspension from the University. Upon such findings, the University of New Orleans will have no responsibility (legal or financial) to any health issues that apply to and have been incurred by me, including death. The Office of International Students and Scholars reserves the right to investigate the validity of private policy benefits in order to meet all listed requirements.