PALM BEACH STATE COLLEGE

OFFICE OF INTERNATIONAL ADMISSIONS AND RECRUITMENT

INTERNATIONAL STUDENT HEALTH INSURANCE COMPLIANCE FORM

This form has been designed to assist international students in complying with the College's rule requiring all international students to have a health and accident insurance in order to register or enroll in classes. If you wish to purchase an alternate policy, you must provide proof that your proposed policy provides benefits at least comparable to those required by PBSC. The following types of plans are **NOT** accepted:

- Travel insurance
- Short-term in-bound insurance policies
- Reimbursement plans
- International Insurance carriers
- Any plan that does not fully meet each of the 13 benefit requirements of this compliance form

Student must complete Section I below and have their insurance carrier to complete Section II and return it along with a copy of the policy Schedule of Benefits to the Office of International Admissions.

SECTION I – *To be completed by Student*

Print Name: _____ **PBSC Student ID #----------**

I hereby permit my insurance company to release the following information to personnel at Palm Beach State College. Also, I understand the international insurance requirements established by PBSC and agree to abide by them. I understand that alternate insurance policies are approved for limited periods not exceeding one year, and that requirements for alternate policy coverage are subject to change. I further understand that I must have my policy reviewed at the end of the approval period indicated below.

I understand that, if alternate insurance is not approved, this does not mean that PBSC or any of its employees recommend that I cancel any existing, pending or proposed insurance coverage. A denial implies only that the policy presented does not meet the minimum criteria established by PBSC with respect to specific medical insurance coverage criteria for registration and/or enrollment.

Signature: _____ **Date**: _____ / _____ / _____

SECTION II – *To be completed by the Insurance Company*

Student Name: _____

Insurance Co. Name: _____

Policy #: _____ **Dates of Coverage: (Beginning - Ending)** _____

U. S. Claims Agent Name: _____

U. S. Claims Agent Address: _____

U. S. Claims Agent Phone: (_____) _____ _____ **Fax Number:** (_____) _____ _____ _____

IMPORTANT: The following plans do not meet the waiver criteria: International Insurance carriers; travel insurance, short-term medical plans, reimbursement plans, *Individual Subsidized ACA coverage from Healthcare.gov* (except for dependents), or any plan that does not fully meet each of the 13 benefit requirements on this compliance form.

Please state YES (meets requirements) or NO (does not meet) for each of the coverage requirements and indicate which page number of the attached Schedule of Benefits, the benefit is indicated:

1. ☐ **YES** or ☐ **NO** **Coverage** is pre-paid and continuous. Please indicate the **period of coverage**:

   ☐ **Annual: 8/19/25 to 08/18/26** ☐ **Fall: 08/19/25 to 01/01/26**

   ☐ **Spring: 01/02/26 to 08/18/26** ☐ **Summer: 05/18/26 to 08/18/26**

2. ☐ **YES** or ☐ **NO** **Policy:** The policy is Affordable Care Act (ACA)-compliant, complies with all state and federal mandates, and is registered in the United States. **PAGE NUMBER:** _____

3. ☐ **YES** or ☐ **NO** **Routine Health Care:** The policy provides coverage for routine preventative services per Federal Law/ACA guidelines. **PAGE NUMBER:** _____

4. ☐ **YES** or ☐ **NO** **Insurance Carrier** must have a rating of either "A" or above by A.M. Best or "A -" or above by Standard & Poor's Claims-Paying Ability**. PAGE NUMBER:** _____

5. ☐ **YES** or ☐ **NO** **Pre-Existing Conditions:** Plan does not exclude pre-existing conditions. **PAGE NUMBER:** _____

6. ☐ **YES** or ☐ **NO** **Inpatient /outpatient mental care:** Inpatient/outpatient mental health care are paid at a minimum of 80% in-network or 60% out-of-network of the usual and customary fees with no internal limitations. **PAGE NUMBER:** _____

7. ☐ **YES** or ☐ **NO** **Basic Benefits:** Medical expenses are paid at a minimum of 80% in-network or 60% out-of-network of usual, reasonable, and customary charges without specific limits on charges such as hospital room and board, hospital miscellaneous, physician visits, surgery, and anesthesia with no internal limitations. **PAGE NUMBER:** _____

8. ☐ **YES** or ☐ **NO** **Maternity Benefits:** Maternity benefits treated as any other temporary medical condition. **PAGE NUMBER:** _____

9. ☐ **YES** or ☐ **NO** **Pharmacy Coverage:** Policy provides pharmacy copays with no maximum policy limit. **PAGE NUMBER:** _____

10. ☐ **YES** or ☐ **NO** **Deductible:** Deductible is no greater than $250 per policy year. **PAGE NUMBER:** _____

11. ☐ **YES** or ☐ **NO** **Minimum Coverage:** The policy provides unlimited maximum benefit for covered injuries and sickness per policy year. **PAGE NUMBER:** _____

12. ☐ **YES** or ☐ **NO** The policy does not exclude coverage for less than **full-time** student enrollment status. **PAGE NUMBER:** _____

13. ☐ **YES** or ☐ **NO** **Medical Evacuation & Repatriation:** The policy provides a minimum of $25,000 for repatriation of remains and a minimum of $50,000 for medical evacuation to the home country, including expenses associated with an attendant, when medically necessary. **PAGE NUMBER:** _____

I have verified the information on this form and completed each item above. I certify that the coverage indicated is now in force. If the above noted policy is terminated, I will notify Palm Beach State College, Office of International Admissions and Recruitment.

Name: _____ **Title:** _____ **Telephone: (____)** _____

Signature: _____ **Date:** ____ / ____ / ____

Please return completed form along with a copy of Schedule of Benefits and proof of Payment in Full to:

Office of International Admissions and Recruitment
Palm Beach State College
4200 South Congress Avenue, Lake Worth, FL 33461
Tel: (561) 868-3029 Fax: (561) 868-3623 Email: international@palmbeachstate.edu

---

FOR PBSC OFFICE USE ONLY

Approved until: _____ **Denied:** _____

Authorized Signature: _____ **Date:** _____ / _____ / _____

Updated: 4/16/25