LIBERTY UNIVERSITY | INTERNATIONAL STUDENT CENTER

Certification of Alternative Insurance

In order for the alternative insurance policy to be acceptable, the policy must be the student's primary health insurance policy and meet all of the requirements listed below. Verification must be obtained from an authorized representative of the insurance company or benefits coordinator. If the alternative insurance is not acceptable, the student is expected to enroll and pay the premiums associated with the designated International Student Health Insurance Plan. This Certification of Alternative Insurance is only valid for one (1) semester and must be submitted for each semester by the posted deadline. **Liberty University relies on representations made on this form and will not review individual policy documents. Making false statements on this form may result in civil or criminal liability. Certification of Alternative Insurance eligibility, deadline, and policy are outlined on the Liberty.edu/ISC**

Step 1 To be completed by the STUDENT (please read carefully).

Student's Name *Last/Surname* *First/Given* *Middle* *Student ID #* *Semester*

Insurance Policy ID # Name(s) of dependent(s) covered under the alternate insurance policy *Phone #*

I request my insurance company to release the requested information below to Liberty University.

I understand that my alternative insurance policy must provide equivalent coverage to the International Student Insurance Policy provided by Liberty University for me to meet the criteria specified below. I understand that my alternative insurance policy being deemed acceptable based on the representations herein is in no way an endorsement of my alternative insurance policy by Liberty University, nor is it a declaration of equivalence by the university. If I use an acceptable alternative insurance policy, I agree to maintain the same alternative coverage throughout the semester for which this certification form was submitted. I understand that any medical expenses not covered by my alternative insurance policy are my sole responsibility and that failure to pay medical bills may negatively affect my or my parents' credit rating, which may also affect certain immigration-related benefits.

Student Signature *Date*

Step 2 To be completed by authorized representative of the insurance company or benefits coordinator.

Company Name *Email*

Address

Phone *Fax*

Please indicate below which items are included in the above-named student's insurance coverage. Liberty University acknowledges that the responses below do NOT constitute legally binding documentation of coverage or determination of coverage in a particular matter, but serve as an unofficial reporting of the student's general type of insurance plan and coverage. In order for the alternative insurance policy to be acceptable, the policy must meet or exceed the below criteria. The insurance plan covering the student named above include:

1.	Emergency, non-emergency, routine health care, mental health benefits, and prescription medication.	❒ Yes	❒ No
2.	Benefits for care provided by qualified, licensed medical doctors in qualified hospitals, outpatient clinics, and offices for covered illness/injuries within the United States.	❒ Yes	❒ No
3.	Benefits for covered medical expenses in the amount of at least $250,000 per covered accident or illness.	❒ Yes	❒ No
4.	Full coverage for students with living situations that would require emergency medical transport and repatriation of mortal remains outside of the U.S.	❒ Yes	❒ No
5.	Coverage of at least 80 percent of preferred provider's negotiated charges and at least 60 percent of non-preferred provider's reasonable and customary charges.	❒ Yes	❒ No
6.	Coverage of school-sanctioned athletic-related injuries (including intramural and interscholastic sports) at the policy maximum (i.e., same level of coverage as non-athletic injuries).	❒ Yes	❒ No
7.	The policy is not a stand-alone travel, short-term, or gap policy.*	❒ Yes	❒ No

**Primary health policies, which incorporate extensions of coverage to the U.S. and meet all of the above criteria for the duration of the school term, will be considered for a waiver.*

Date Insurance Effective_____/_____/_____ Date Insurance Expires_____/_____/_____

The information above is correct to the best of my knowledge but in no way binds the insurance company.

Name and title of authorized insurance representative/benefits coordinator completing this form

Signature of Authorized Insurance Representative/Benefits Coordinator

Date

To be completed by the International Student Center staff.

Certification of Alternative Insurance:

Step 3

- ❒ Approved
- ❒ Denied

International Student Center Representative Signature

Date

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