CALIFORNIA STATE UNIVERSITY
SAN BERNARDINO

PETITION TO APPROVE ALTERNATE INSURANCE POLICY

STUDENT INFORMATION		
Name:		SID#:
Local Address:		
Telephone #:		

INSURANCE PROVIDER INFORMATION	
Insurance Provider Name:	
Insurance Address:	

TERM PETITIONING TO WAIVE				
Annual ☐	Fall ☐	Spring ☐	Summer ☐	Winter ☐

TO COMPLY WITH CALIFORNIA STATE UNIVERSITY EXECUTIVE ORDER 1082, VISA STUDENTS ARE REQUIRED TO OBTAIN AND MAINTAIN INSURANCE COVERAGE FOR HEALTH, MEDICAL EVACUATION, AND REPATRIATION DURING THEIR PERIOD OF ENROLLMENT AT CSU SAN BERNARDINO IN AMOUNTS AT LEAST EQUAL TO THOSE SPECIFIED BY THE UNITED STATES INFORMATION AGENCY (USIA) AND THE ASSOCIATION OF INTERNATIONAL EDUCATORS (NAFSA). YOUR INSURANCE POLICY NEEDS TO MEET THE FOLLOWING CRITIERIA:

- THE POLICY IS VALID UNTIL AT LEAST THE BEGINNING OF THE FALL TERM OF THE FOLLOWING ACADEMIC YEAR;
- THE MEDICAL BENEFIT IS AT LEAST $100,000 PER CONDITION AND THE CO-PAYMENT DOES NOT EXCEED 25%;
- THE REPATRIATION BENEFIT IS AT LEAST $7,500;
- THE MEDICAL EVA[UATION BENEFIT IS AT LEAST $10,000;
- THE DEDUCTIBLE DOES NOT EXCEED $100 PER ILLNESS OR INJURY;
- THE POLICY MUST BE FUNDED IN THE UNITED STATES;
- THE POLICY MUST COMPLY WITHT TITLE 9 AND/OR THE CIVIL RESTORATION ACT OF 1987, (I.E. MUST NOT GIVE ANY EVALUATION OF PREGANANCY OR COST OF PREGNANCY, NOR LIST PREGNANCY AS A SEPARATE BENEFIT);
- THE POLIY MUST NOT REQUIRE MORE THAN A SIX (6)-MONTH, TREATMENT PERIOD PRIOR TO COVERAGE AND MUST NOT REQUIRE MORE THAN A SIX (6)-MONTH WAITING PERIOD FOR PRE-EXISTING CONDITIONS.

PLEASE COMPLETE THE FOLLOWING TO ESTABLISH THAT YOUR CURRENT POLICY FULFILLS THE ABOVE REQUIREMENTS:		
1. DATES OF COVERAGE PERIOD:		
2. MEDICAL BENEFIT PER CONDITION:		CO-PAYMENT:
3. MEDICAL EVALUATION BENEFIT:		
4. REPATRIATION BENEFIT:		
5. THE DEDUCTIBLE IS:		
6. THE POLICY IS FUNDED IN THE USA (LOCATION IN THE USA WHERE FUNDS ARE HELD):		
7. THE POLICY COMPLIES WITH TITLE 9 AND/OR THE CIVIL RESTORATION ACT OF 1987?	YES ☐	NO ☐
8. PRE-EXISTING CONDITIONS/WAITING PERIOD:	_____MONTHS/_____MONTHS	

YOU MUST ALSO SUBMIT WITH THIS APPLICATION: AN *ENGLISH LANGUAGE* COPY OF YOUR INSURANCE POLICY BENEFITS AND CURRENT DATES OF COVERAGE FOR VERIFICATION.

_____
Student Signature *Date*

OFFICE USE ONLY					
Date Received:		By:		Recommendation:	
Alternate Insurance:	Approved ☐	Denied ☐			

_____
Director Signature *Date*