MIRACOSTA COMMIUNITY COLLEGE DISTRICT
APPLICATION FOR HEALTH INSURANCE WAIVER
INTERNATIONAL STUDENTS ONLY

Should you have any questions completing this form, please call 760.757-2121 EXT6590 or email lcargile@miracosta.edu.

Your health is important to us and critical to your success at MiraCosta Costa Community College District (MCCD). The waiver process is designed to assist you in selecting a health insurance plan that will assist with your medical expenses should you have an accident or sickness and one that also complies with Covered California United States Health Care Reform insurance laws.

International Students applying for a MCCD student insurance waiver should complete this form and return it to The English Language Institute or email it to lcargile@miracosta.edu. Insurance **must be received no later than the first day of class.**

Waivers **may** be approved for the following types of insurance plans:

- ► Employer Group Health Plans with acceptable deductible levels
- ► Sponsored Health Insurance Plans approved through the Institute for International Perspectives
- ► Individual Health Insurance Plans that meet Covered California laws

Documentation required for approval:

Employer Group Plans: ***Complete section A and provide a copy of the front and back of your current insurance ID card.***

Individual Health Plans: ***Complete sections A and B and provide a copy of the front and back of your current insurance ID card.***

****For INDIVIDUAL PLANS, please provide the insurance plan document listing all benefits and exclusions of the policy.**

- ► Short term in-bound travel policies/policies not written in English/policies without benefits listed in US dollars
- ► Short term/limited duration/sickness and accident insurance plans
- ► Foreign insurance plans with US affiliates/representatives or reimbursement programs
- ► Health insurance plans that do not meet health care laws

SECTION A: Student Information

Last Name	First Name	MI	Student ID	Date of Birth

Current Address:	City	State	Zip
		CA	

Email Address:

Telephone Number: Alternate Number:

Student Status: □ New Student □ Returning Student

Policy valid through semester you are intending to enroll: □ Spring 20_____ □ Fall 20_____ □ Summer 20_____

Please provide the following.

Select Type of Plan:	Individual		Employer Group Plan		
If this is an employer group health plan, please provide the name of the employer					

Name of the insurance provider						
Insurance company phone number						
Name of the Primary Insured						
Relationship to Primary Insured	Self		Parent		Spouse/Partner	
How long have you been covered under your current medical plan						

SECTION B: Health Insurance Information – Please provide the following information about your health insurance:

Waiver Criteria (please answer the following questions and provide page numbers from your attached policy.)

Does your plan provide each of the following:

1.	**Unlimited Sickness or Accident Benefit**	Yes		No		Page No.	
2.	**No lifetime maximum amount on the following Health Benefits:**						
	Preventive and Wellness Services	Yes		No		Page No.	
	Prescription Coverage	Yes		No		Page No.	
	Outpatient Services	Yes		No		Page No.	
	Hospitalization	Yes		No		Page No.	
	Emergency Services	Yes		No		Page No.	
	Maternity and Newborn Care	Yes		No		Page No.	
	Laboratory Services	Yes		No		Page No.	
	Chronic Disease Management	Yes		No		Page No.	
	Mental/Behaviorial health and substance use disorders	Yes		No		Page No.	
3.	**No pre-existing condition waiting period**	Yes		No		Page No.	
4.	**Co-Insurance: 80% insurance/20% your responsibility**	Yes		No		Page No.	

International students, per Federal Visa requirements, must have the ADDITIONAL benefits in their insurance plan:

(http://j1visa.state.gov/sponnsors/how-to-administer-a-program/)

1.	**No greater than a $500.00 deductible per person***	Yes		No		Page No.	
2.	**Minimum of $25,000.00 in repatriation benefits**	Yes		No		Page No.	
3.	**Minimum of $50,000.00 in medical evacuation benefits**	Yes		No		Page No.	

*A deductible is what you pay out of your pocket before the insurance starts to pay.

You will be notified via email once your waiver has been processed. Please allow ten (10) business days for processing.

If there is other relevant information you would like us to know about your health policy, please provide it here.

AP 5030: Fees
N. International Student Medical Insurance (Education Code section 70902(b)(9)) The district offers accident and sickness insurance for all international students. Premiums are charged to each international student every fall and spring semester at the time of enrollment. Students may seek an exemption from the mandatory insurance policy if they can provide a copy of a comparable health insurance policy (*written in English*), which **includes the following information**:

1. Effective dates of coverage
2. Amount of coverage
3. Outline of covered services, which must include:
   a. Mental-health care with patient care
   b. Hospitalization
   c. Maternity
3. Outline of covered services, which must include continued:
   d. Medical evacuation
   e. Repatriation
   f. List of excluded services
   g. Information about how to reach the insurance company (address, telephone number, etc.)

Exemptions from the mandatory insurance premium must be approved prior to fall and spring registration by the Director of Risk Management.

If approved, I agree to maintain the approved health insurance policy throughout the academic term noted above.

Date:

Student/Parent/Guardian Signature: _____

PRINT NAME OF PARENT/GUARDIAN (if student is under age 18)

Office Use Only

Date Approved:	Initials:
Date Denied:	Initials
Reason for denial:	

Release from Liability

Print Name: _____ **Student ID:** _____

I certify that the health insurance coverage documented on the Petition to Approve an Alternate Health Insurance Plan is in effect and will remain in effect for the entire semester for which I am requesting this waiver.

I understand that the sole purpose of the District's review of this information is to determine if I qualify for a waiver of enrollment in the group international student health insurance plan. I understand that I will be responsible for all medical insurance expenses incurred by me, including deductibles, copays, and charges that may be billed and neither the District nor its Group International Student Health insurance Plan will be responsible for any medical or . I understand that the District's review and/or approval of this application **does not** constitute a determination by the District as to the adequacy of this coverage for any purpose.

I understand that it is my sole responsibility to maintain the minimum coverage required by applicable federal and state regulations. I further understand that failure to maintain health insurance coverage while attending MiraCosta College is a violation of District policy.

My signature certifies that I agree to these conditions and statements.

_____ _____

Student Signature Date

**The student signature is required. If the student is below age 18, this form must be co-signed by the parent or guardian*

Insurance Purchase Waiver

MCCD students in F-1 status may be eligible to waive the MiraCosta Community College District (MCCD) insurance requirement if medically insured by a parent or spouse through a U.S. employer. Students on valid Optional Practical Training (OPT) may be eligible to waive this requirement if covered by a U.S. employer. All insurance coverage must meet the standards of the American Health Care Act (2017).

□ I have continuous medical insurance coverage through my OPT employer or through the employer of my parent/spouse.

□ I understand that it is my responsibility to maintain my continuous medical coverage as long as I am in the U.S. on a valid I-20 from MCCD, including any OPT period.

□ I agree to purchase the supplemental Medical Evacuation/Repatriation coverage during the time that I am enrolled as an F-1 student at MCCD and any OPT period.

□ I understand that I will have to resubmit an Insurance Purchase Waiver and proof of medical coverage each semester.

REQUIRED: Attach proof of coverage (i.e. explanation of benefits) that shows name of covered party and dates of coverage. Attach receipt for supplemental insurance.

If I fail to purchase medical insurance, I realize that I will be financially responsible for all my health expenses, costs of any emergency care services, medical evacuation or repatriation of remains, if necessary. I may also encounter insurance companies who refuse to pay for certain expenses in the future due to any break in coverage.
I understand that eligibility for any refund (partial or full) is subject to review and determination by MCCD or insurance company.

Print and sign. Submit to ELI with any required attachments.

Student Name	Student ID
Signature	Date

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