HUMBOLDT STATE UNIVERSITY

Office of Extended Education • **1 Harpst Street, Arcata, California 95521-8299 • voice 707-826-3731 • fax 707-826-5885**

PETITION TO APPROVE ALTERNATE INSURANCE

All non-immigrant students are required to maintain acceptable health insurance coverage while enrolled at Humboldt State University. Students are automatically enrolled in "CSU HealthLink" which fulfills all CSU coverage requirements. However, students who have other insurance coverage which meets the minimum requirements may submit this petition for consideration to substitute the student's existing health insurance plan.

Students who petition for approval of an alternate policy must complete Section A, below, and have their insurance company complete Section B and provide a copy of the policy translated into English prior to registering for classes.

For consideration, you must provide evidence that you currently have a policy which meets the following criteria:

1) Medical benefits of at least $50,000 per accident or illness, with a copayment of no more than 25%;
2) Repatriation of remains in the amount of $7,500;
3) Expenses associated with the medical evacuation of the student to his or her home country in the amount of $10,000;
4) A deductible not to exceed $500 per accident or illness; and
5) The policy covers pre-existing conditions after 6 months of continuous coverage.

Section A: Student Information

Name: _____ HSU ID#: _____ Policy # _____

Local Telephone #: _____ Email Address: _____

Local Address: _____

Certification by Student

I certify that I am in compliance with the insurance requirements as specified by Humboldt State University, and I agree to maintain appropriate insurance coverage throughout my attendance. I will notify the University immediately should there be any changes to my insurance policy.

Signature of Student _____ Date _____

Section B: Certification by Insurance Company

I certify that the student named on this form currently maintains an insurance policy which fulfills the minimum requirements as specified. Attached is a copy of the policy, translated into English. The specific terms of the policy include:

Effective dates of coverage: _____

Medical benefit per condition: $ _____ Copayment: _____ % Deductible: $ _____

Repatriation benefit: $ _____ Medical evacuation benefit: $ _____

Waiting period for pre-existing conditions: _____

Insurance Company: _____ Telephone #: _____

Address: _____

_____

Name of representative completing this form ***(Please Print)***: _____

Signature of Insurance Company Representative _____ Date _____

Please mail or fax (see above letterhead) or scan and send electronically to *angles@humboldt.edu*.