

FAST TRAIN Programs

Instructions to Insurance Company Representative OR Benefits Administrator –

Student Name: Last _____ First _____

Insurance Company Name _____

Policy No. _____ Dates of Coverage _____

Claims Agent U.S. Address _____

Claims Agent U.S. Phone Number _____

Please state either “YES” the insured’s policy meets or exceeds the minimum benefit listed **OR** “NO” for benefits not covered or that do not meet the stated minimum amounts of coverage required.

Employer Group Plans, please complete 1 - 4 only.

- ___ 1. Medical benefits of at least \$50,000 per accident or illness;
- ___ 2. The annual deductible does not exceed \$500;
- ___ 3. The policy is valid for the duration of my stay at George Mason University in the current academic year;
- ___ 4. Cost of medical evacuation (\$10,000) and repatriation (\$7,500) are included¹

Employer Group Plans, please stop here.

- ___ 5. Coverage is provided by a company licensed to do business in the United States and has an United States claims office and telephone number.
- ___ 6. Proof that insurance is paid in full and cannot be cancelled for the remaining academic year. Monthly payment plans do not qualify.
- ___ 7. Covered for pre-existing conditions within 6 months of being insured;
- ___ 8. Provide coverage anywhere in the U.S. for outpatient and inpatient **medical care**. A policy that provides coverage on an “emergency care only” basis does not meet this requirement.
- ___ 9. Provide coverage anywhere in the U.S. for outpatient and inpatient **mental health care**, including suicide attempts, substance and alcohol abuse treatment.
- ___ 10. Maternity/Pregnancy care (females only).

¹ Coverage with **On Call International** is available for international students for a fee at the Student Health Insurance Office. This coverage provides unlimited worldwide medical evacuation and repatriation, 24 hours travelers assistance and accidental death and dismemberment coverage up to a \$10,000 maximum.

*The Student Health Insurance Office reserves the right to review policies.
If a policy does not meet ALL criteria listed above, a waiver request will be denied.*

Insurance Company Representative or Benefit Administrator (Please read and sign) –

I have verified the information on this form and completed each item. I certify that the coverage indicated is now in force. If the above noted policy is terminated before the end of the duration of the student’s stay at George Mason University in the current academic year, I will notify the Student Health Insurance Office immediately: phone 703-993-2827 and 703-993-4324, fax 703-993-3955, email: insure@gmu.edu.

Print Name _____ Title _____

Signature _____ Date _____

Phone _____ Fax _____

Address _____
Street, City, State, Zip Code, Country