PETITION TO APPROVE ALTERNATE HEALTH INSURANCE PLAN

Name PRINT	Date:
Local Address:	
Telephone Number:	Student ID#
Email Address:	

The policy is valid through semester you are intending to enroll:
( ) Spring 20___, ( ) Fall 20___, ( ) Summer 20___.

Recommended insurance coverage to comply with Affordable Care Act and international student standards your policy meets the following criteria:

1. Unlimited maximum on benefits (including pregnancy)
2. No Pre-existing condition limitation
3. The repatriation benefit is at least $25,000
4. The medical evacuation benefit is at least $50,000.

Please fill in each of the categories below to show how your alternate policy compares to the recommended insurance coverage. You must attach an English copy of your policy benefits, a list of coverage services and excluded services to this petition explicitly documenting the following provisions:

Name of Insurance Company:	
Insurance Company's Address:	
Policy Number:	Telephone Number:
Effective date of coverage:	Expiration date of coverage:
Medical Benefit per condition: 1. $_____________USD 3. Pre-existing condition limitation Yes __ No__	
4. Repatriation benefit: $____________USD;5. Medical Evacuation Benefit: $_________ USD	

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

Student/Parent/Guardian Signature:___________________________________ **Date**: _______

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

Office Use Only: Date Approved: ______________________Initials: _______
Date Denied: ________________________ Initials: _______
Reason for denial: ____

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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 expenses. 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 *Dates*

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