Stanford | Vaden Health Center

International Student Insurance Coverage Certification Form

To request an exception to the mandatory purchase of Cardinal Care, this form must be completed on an annual basis and submitted to Vaden Health Center's Insurance Office.

SUBMIT VIA POSTAL MAIL OR DELIVERY SERVICE, OR DELIVER IN PERSON, TO:	FAX TO:	EMAIL TO:
Vaden Health Center Insurance Office 866 Campus Drive Stanford, CA 94305	**(650) 725-9970**	**healthinsurance@stanford.edu**

STUDENT LAST NAME	STUDENT FIRST NAME	STANFORD UNIVERSITY I.D. NUMBER	APPOINTMENT START AND END DATES

I certify that the above-named individual has insurance coverage for the period of _____ (BEGIN DATE) **through** _____ (END DATE) **which meets or exceeds the following:**

If "No," please explain:

1. **Annual deductible less than $1,000 USD** ❑ Yes ❑ No
   (If a foreign currency applies, please indicate the applicable amount.)
2. **Lifetime benefit** (complete **a** *or* **b**)**:**
   - **a. Lifetime aggregate maximum benefits of at least $2,000,000 USD** ❑ Yes ❑ No
     (If a foreign currency applies, please indicate the applicable amount.)
   - **b. Maximum per condition/per lifetime benefit of at least $500,000 USD** ❑ Yes ❑ No
     (If a foreign currency applies, please indicate the applicable amount.)
3. **Covers inpatient and outpatient medical care in the San Francisco Bay Area in the U.S.** ❑ Yes ❑ No
4. **Covers inpatient and outpatient mental health care in the San Francisco Bay Area in the U.S.** ❑ Yes ❑ No
5. **Covers prescriptions** ❑ Yes ❑ No
6. **Covers non-emergency as well as emergency care** ❑ Yes ❑ No
7. **Pre-existing conditions** (complete **a** *or* **b**)**:**
   - **a. Policy covers pre-existing conditions** ❑ Yes ❑ No
   - **b. The insured individual has met applicable waiting periods** ❑ Yes ❑ No

Although not a requirement of Stanford University, the U.S. Department of State requires that J1 visa holders have an insurance policy with minimum coverage of $25,000 USD for repatriation of remains and $50,000 USD for medical evacuation.

NAME OF INSURANCE COMPANY	INSURANCE POLICY NUMBER

AGENT REPRESENTING INSURANCE COMPANY | SIGNATURE OF AGENT | DATE

TELEPHONE NUMBER | ADDRESS

I have enrolled in the above insurance program and verify that the information contained herein is true and accurate. I will maintain this coverage for the period listed and will inform Vaden Health Center's Insurance Office of all changes.

SIGNATURE OF STUDENT | DATE