

## MEDICAL INSURANCE VERIFICATION FORM

Filling out this form is a **requirement** for registration **only** if you are **not** purchasing UC San Diego Student Medical Insurance. **Complete and return this form at least 30 days before your program start-date. Please also attach proof in English of coverage from your medical insurance company. All information fields are required.**

### 1 STUDENT INFORMATION:

Family Name	First Name
Student's Email	Date of birth month/day/year (e.g. JAN 01, 1979)

### 2 FOREIGN MEDICAL INSURANCE COMPANY INFORMATION:

Company Name
Date insured from month/day/year (e.g. JAN 01, 1979)      Date insured to month/day/year (e.g. JAN 01, 1979)

**Important Note: Dates of insured coverage must include the entire length of the student's program at UCSD.**

### 3 INSURANCE COVERAGE AMOUNTS

(all 5 items must be equal to or better than UCSD Required Minimum Coverage):

Enter Below: insurance coverage in equivalent U.S. dollars (must equal or exceed UC San Diego Required Minimum Coverage)	UCSD Required Minimum Coverage
1. \$                      per illness or injury	1. \$250,000 USD per illness or injury
2. \$                      for medical evacuation	2. \$25,000 USD for medical evacuation
3. \$                      for repatriation of remains	3. \$10,000 USD for repatriation of remains
4. \$                      deductible per illness/injury	4. A deductible not to exceed \$75 USD per illness or injury
5. Coverage by our company is at _____ % after the deductible.	5. 100% coverage of all medical care and prescribed medicines after the deductible

Foreign medical insurance company payment procedure with insured student: (check one)

- Student pays medical fees and is later reimbursed by the medical insurance company.  
 Insurance company is billed directly  
 Other, please explain: \_\_\_\_\_

#### Required:

- Official Stamp from your medical insurance company to confirm above coverage and dates.
- English-speaking claims representative in your insurance company:

Name		
Phone		
Address	Street	Apartment Number
City	Postal Code	Country
Email of English-speaking representative in Insurance Company (Please print clearly.)		

Official Stamp of Medical  
Insurance Company