Proof of Medical Insurance for J-1 Visa Exchange Visitors

Instructions:

1. Have this form completed by an official of your insurance company and original copy returned to you.
2. Attach to this form a complete copy of your insurance policy or schedule of benefits in English.
3. Please note that all J-1 holders and their dependents are required by the Exchange Visitor Program (EVP) and the Department of Homeland Security (DHS) regulations to have health insurance while in the United States.
4. Program participants and their dependents are required to have medical insurance coverage with the following minimum benefits [22 CFR 62.14]:
   • Medical benefits of at least $50,000 per accident or illness
   • Repatriation of remains in the amount of $7,500
   • Medical evacuation of the exchange visitor to his or her home country in the amount of $10,000
   • A deductible not to exceed $500 per accident or illness.
   • Written proof of policy benefits must be provided in English, with coverage limits converted to US dollars.
5. The policy must be either:
   • Underwritten by an insurance corporation having an A.M. Best rating of "A-" or above, an Insurance Solvency International, Ltd. (ISI) rating of "A-i" or above, a Standard & Poor's Claims-paying Ability rating of "A-i" or above, a Weiss Research, Inc. rating of B+ or above.
   • Backed by the full faith and credit of the government of the exchange visitor's home country.
   • Offered through or underwritten by a federally qualified Health Maintenance Organization (HMO) or eligible Competitive Medical Plan (CMP) as determined by the Health Care Financing Administration of the U.S. Department of Health and Human Services.
6. Submit all of the above to ITU along with your completed DS-2019 Request Form.

A. CURRENT MEDICAL INSURANCE COVERAGE

Name of Subscriber: __________________________________________________________

Name of Insurance Company (Carrier): __________________________________________

Policy Number: __________________ Policy Effective Dates: ______________________

_________________________________________ _________________________________

Policy Holder Signature: ___________________________ Date: _______________________

*ATTACH A COPY OF MEMBERSHIP CARD
B. APPLICATION FOR MEDICAL COVERAGE PENDING

Name of Subscriber: ________________________________________________________

Name of Insurance Company (Carrier): _________________________________________

Policy Effective Date: ____________________________

_______________________

Policy Holder Signature: ____________________________ Date:

*ATTACH COPY OF ENROLLMENT FORMS

C. HEALTH INSURANCE PLEDGE

I pledge to maintain adequate insurance coverage (as outlined above) for myself and my dependents for the full duration of my J-1 program. I will report compliance at the start of each academic year. Additionally, I understand that failure to comply with the insurance requirement will result in termination of my J-1 program and the Department of State will be notified immediately.

Name of J-1 Exchange Visitor: ____________________________

_______________________

Signature: ____________________________ Date: