

The current regulations governing the J-1 Exchange Visitor Program requires you and any dependents who accompany you to have medical insurance coverage. You are required by the United States Department of State to have at least:

1. Medical benefits of at least \$100,000.00 per accident or illness
2. Repatriation of remains in the amount of \$25,000.00
3. Expenses associated with medical evacuation in the amount of \$50,000.00
4. A deductible not to exceed \$500.00 per accident or illness

You will find enclosed a Certification of Medical Insurance form. This form **MUST** be completed by your insurance agent, signed by the prospective exchange visitor, and submitted to the Office of International Affairs along with other J-1 application documents.

If you do not have this coverage, you can and must secure this medical coverage immediately on your arrival through our Office of International Affairs.

Certification of Medical Health Insurance Coverage J-1 International Student

Name:

_____ (Last/Family)

_____ (First)

_____ (Middle)

Personal Email: _____

Expected Arrival Date: _____ (Month/Day/Year) Expected Departure Date: _____ (Month/Day/Year)

I certify that the above-named individual and _____ dependents have medical benefits of at least \$100,000.00 per accident or illness, repatriation of remains in the amount of \$25,000.00, expenses associated with the medical evacuation of the exchange visitor to his or her home country in the amount of \$50,000.00, and a deductible not to exceed \$500.00 per accident or illness.

Please indicate the dates of your insurance coverage:

Dates of Coverage: From: _____ (Month/Day/Year) To: _____ (Month/Day/Year) _____
Name of Medical Health Insurance Company

Signature of Agent Representing
Medical Health Insurance Company

Date

Please attach **all** of the following documentation with this form:

- Proof of your medical health insurance coverage (such as an ID card or letter from insurance company).
- Verification of dates of coverage.
- A description, **in English**, of the conditions of your medical health insurance coverage. You may provide your own translation.
- If your medical health insurance is based on employee benefits provided to your parent, documentation verifying the age through which you are eligible for coverage.

I certify that I have enrolled in the above medical health insurance program. I will continue to maintain this coverage and will notify your office of any changes and provide appropriate documentation of any changes. I will provide documentation of continuation of the required coverage upon request for extension of J-1 status.

By agreeing to and submitting this form, I acknowledge that the information provided about my medical health insurance coverage is true and accurate and I understand that I must carry the requisite insurance for as long as I am enrolled at the University of Louisiana at Lafayette. If this document contains any false, fraudulent or misrepresented information, the University of Louisiana at Lafayette will have no responsibility (legal or financial) to any health issues that apply to and have been incurred by me, including death. I acknowledge that I am legally responsible for any and all medical expenses during my enrollment at the University of Louisiana at Lafayette. Further, I understand that the Office of International Affairs along with Student Health Services reserves the right to investigate the validity of private policy benefits in order to meet all listed requirements.

Signature of Exchange Visitor

Date