INTERNATIONAL STUDENT & SCHOLAR SERVICES

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J-1/J-2 EXCHANGE VISITOR MEDICAL INSURANCE REQUIREMENTS

SECTION A: MEMORANDUM OF UNDERSTANDING

I, _____ agree that I am in compliance with the insurance regulations as specified in **22 C.F.R. § 62.14** of the Exchange Visitor Regulations copy. I understand that it is my responsibility to maintain my status and continue medical insurance coverage for myself and my J-2 dependents throughout my J-1 program. I further understand that my program will be terminated if I willfully fail to maintain the said medical coverage for myself and my dependents.

Signature Date

22 C.F.R. § 62.14

(a) Sponsors shall require each exchange visitor to have insurance in effect which covers the exchange visitor for sickness or accident during the period of time that an exchange visitor participates in the sponsor's exchange visitor program. Minimum coverage shall provide:
1. medical benefits of at least $50,000 per accident or illness;
2. repatriation of remains in the amount of $7,500;
3. expenses associated with medical evacuation of the exchange visitor to his or her home country in the amount of $10,000; and
4. a deductible not to exceed $500 per accident or illness.

(b) An insurance policy secured to fulfill the requirements of this section:
1. may require a waiting period for pre-existing conditions which is reasonable as determined by current industry standards;
2. may include provision for co-insurance under the terms of which the exchange visitor may be required to pay up to 25 percent of the covered benefits per accident or illness; and
3. shall not unreasonably exclude coverage for perils inherent to the activities of the exchange program in which the exchange visitor participates.

(c) Any policy plan or contract secured to fulfill the above requirements must, at minimum, be:
1. Underwritten by an insurance corporation having an A.M. Best rating of "A-" or above, an Insurance Solvency International, Ltd. (ISI) rating of "A-" or above, a Standard and Poor's Claims-paying Ability rating of "A" or above, a Weiss Research, Inc. rating of B+ or above or such other rating service as the Agency may from time to time specify; or
2. Backed by the full faith and credit of the government of the exchange visitor's home country; or
3. Part of a health benefits program offered on a group basis to employees or enrolled students by a designated sponsor; or
4. 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.

(d) Federal, State or local government agencies, state colleges and universities, and public community colleges may, if permitted by law, self-insure any or all of the above-required insurance coverage.

(e) At the request of a non-governmental sponsor of an exchange visitor program, and upon a showing that such sponsor has funds readily available and under its control sufficient to meet the requirements of this section, the Agency may permit the sponsor to self-insure or to accept full responsibility for such requirements.

(f) The Agency, in its sole discretion, may condition its approval of self-insurance or the acceptance of full financial responsibility by the non-governmental sponsor by requiring such sponsor to secure a payment bond in favor of the Agency guaranteeing the sponsor's obligations hereunder.

(g) An accompanying spouse or dependent of an exchange visitor is required to be covered by insurance in the same amounts [as the principal].

Sponsors shall inform exchange visitors of this requirement, in writing, in advance of the exchange visitor's arrival in the United States.

(h) An exchange visitor who willfully fails to maintain the insurance coverage set forth above while a participant in an exchange visitor program or who makes a material misrepresentation to the sponsor concerning such coverage shall be deemed to be in violation of these regulations and shall be subject to termination as a participant.

(i) A sponsor shall terminate an exchange visitor's participation in its program if the sponsor determines that the exchange visitor or any accompanying spouse or dependent willfully fails to remain in compliance with insurance requirements.

SECTION B: MEDICAL INSURANCE CONFIRMATION

This section must be completed and submitted to International Student and Scholar Services (ISSS) with any of your and your dependents' requests/applications.

Note – If you are a UConn employee benefit recipient, UConn employee health insurance plans DO NOT cover all legally mandated items. You must list below supplemental coverage information in addition to your employee coverage for both yourself and your family members to comply with insurance requirements. Unless provided, your request will not be processed.

J-1 EV's Family Name: _____ **Given Name:** _____
SEVIS ID #: _____ **Date of Birth:** _____
J-1 Category (see #4 of your DS-2019): ☐ Professor ☐ Research Scholar ☐ Short-term Scholar
☐ Specialist ☐ Degree Student (Doctorate, Master's Bachelor)
☐ Non-degree Student
☐ Other (specify): _____

Request Type: ☐ Travel signature ☐ Extension ☐ Out-of-Country Request ☐ Transfer-out
☐ Social Security Letter ☐ DMV Letter ☐ On-campus employment authorization
☐ Off-campus employment authorization ☐ Academic Training
☐ Other (specify): _____

J-1 Principal's Medical Insurance Information:

1. Insurance Company Name: _____ Subscriber's name: _____
   Insurance ID #: _____
   Valid until (mm/dd/yyyy): _____ or ☐ No specify expiration date given

2. Insurance Company Name: _____ Subscriber's name: _____
   Insurance ID #: _____
   Valid until (mm/dd/yyyy): _____ or ☐ No specify expiration date given

3. Insurance Company Name: _____ Subscriber's name: _____
   Insurance ID #: _____
   Valid until (mm/dd/yyyy): _____ or ☐ No specify expiration date given

Does this request include your dependents? ☐ **Yes** ☐ **No** *If yes, complete the following.*

Dependents' Medical Insurance Information:

1. Insurance Company Name: _____ Subscriber's name: _____
   Insurance ID #: _____
   Valid until (mm/dd/yyyy): _____ or ☐ No specify expiration date given

2. Insurance Company Name: _____ Subscriber's name: _____
   Insurance ID #: _____
   Valid until (mm/dd/yyyy): _____ or ☐ No specify expiration date given

3. Insurance Company Name: _____ Subscriber's name: _____
   Insurance ID #: _____
   Valid until (mm/dd/yyyy): _____ or ☐ No specify expiration date given

I certify under penalty of perjury that the above information is true and correct, and all insurance combined meet the requirements stated in 22 C.F.R. § 62.14 for each family member and myself. I further understand that my program will be terminated if I willfully fail to maintain the said medical coverage for myself and my dependents.

_____

Signature Date