

**J Visa Health Insurance Form**  
**International Student Services ♦ University of Hawaii at Manoa**  
**Phone: 808 956-8613; Fax: 808 956-5076**

J-1 students must use this form to document their health insurance coverage. University of Hawaii policy mandates that international students must have health insurance coverage every semester enrolled. The US Department of State mandates that any person holding a J visa (J-1/J-2) must be covered by a health insurance policy with specific types of coverage for all days in the US. New Students cannot register before receiving health insurance clearance. Processing time = 2 days. **New student coverage should begin on the date of arrival in the US. The deadline for continuing J-1 students to submit this form for Fall 08 is August 25, 2008.** This form may be faxed to ISS in advance of arrival.

*The details of your plan must be submitted in English, with US dollar coverage levels, and the dates of coverage.*

**Minimum Levels of Coverage Required**

- \*Minimum coverage period.....arrival date or August 25 – December 21, 2008
- \*Total aggregate medical coverage.....\$100,000 US per incident, or One Million \$ Lifetime Maximum
- \*Deductible .....Maximum \$250
- \* Coverage for major medical and hospital visits including inpatient psychiatric stays.....75% of usual/customary charges (UCC)
- \*Medical Evacuation/Repatriation.....\$10,000/\$7,500  
 ( Note that students purchasing HMSA must select Options 2 or 4 to be federally compliant)

I request approval for the health insurance policy listed below and attach details of the policy or summary that document compliance with the above minimum coverage levels and dates of coverage. I understand these documents are kept on file and will not be returned to me. My J-2 dependents listed below are covered under the same policy or, if not covered under the same policy, I attach separate forms for my J-2 dependents.

Name of insurance company \_\_\_\_\_

Claims Address & Phone #: \_\_\_\_\_

Coverage period from \_\_\_\_\_ to \_\_\_\_\_ (must have minimum coverage period noted above)

Certification: I authorize the ISS and/or University Health Service to contact my insurance company if needed to verify insurance coverage.

LAST NAME: \_\_\_\_\_ First Name : \_\_\_\_\_

Student ID# \_\_\_\_\_ Birth Date: \_\_\_\_\_ Email : \_\_\_\_\_@hawaii.edu

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

J-2 Dependent Names: \_\_\_\_\_  
 \_\_\_\_\_

Certification: I understand it is my responsibility to comply with UHM and federal health insurance requirements for all days I and my dependents are in the US.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**For ISS use only: Approved**      **Hold Reset Date:** \_\_\_\_\_ **By:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Disapproved**       Insufficient coverage     Insufficient documentation      Date: \_\_\_\_\_