J-1

**Student**

**HEALTH INSURANCE PROVIDER CERTIFICATION FORM**

The U.S. government requires all J-1 exchange visitors and their J-2 dependents to maintain minimum health insurance coverage for the duration of their academic programs in the U.S.

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| **STEP 1. This form must be completed by the health insurance provider** | | |
| **Health Insurance Information** | | |
| **Health Insurance Company Name** | **Policy Plan/Type or Number** | |
|  |  | |
| **Name of Primary Insured** | **Dates of Coverage (mm/dd/yyyy – mm/dd/yyyy)** | |
|  | **Start:** | **End:** |
| **Name(s) of any spouse or child (attach additional sheet if necessary)** |  | |
| 1. | 3. | |
| 2. | 4. | |
|  |  | |
| **Required minimum coverage for J-1 and J-2:**   |  |  | | --- | --- | | Kind of Coverage | Specific Level of Coverage | | Medical Benefit | At least USD 100,000 per accident or illness | | Repatriation of Remains | At least USD 25,000 | | Medical Evacuation | At least USD 50,000 | | Deductible per accident or illness | At most USD 500 |  * May establish a reasonable waiting period before pre-existing conditions are covered – “reasonable” is defined by current insurance industry standards; * May include co-insurance provisions, but must pay at least 75% of covered medical expenses; * Does not unreasonably exclude coverage for perils inherent to the activities of the University of Hawaii J-1 Exchange Visitor Program in which the insured exchange visitor participates; and * Is guaranteed through one of the following means:   1. underwritten by a health insurance corporation rated * “A-“ or above by A.M. Best, * “A-“ or above by McGraw Hill Financial/Standard & Poor’s Claims-paying Ability, * “B+” or above by Weiss Research, Inc., * “A-“ or above by Fitch Ratings, Inc., * “A3” or above by Moody’s Investor Services   1. backed by the full faith and credit of the J-1’s home country’s government OR   2. is part of a health benefits program offered on a group basis to employees or enrolled students by a designated sponsor OR   3. offered through or underwritten by a federally qualified HMO or eligible Competitive Medical Plan as determined by the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services. | | |
|  | | |
| **Certification** | | |
| The minimum coverage requirements stated above are provided in this policy/plan. I am qualified to make this certification as an authorized agent/employee of the above insurance provider. | | |
| **Signature of Representative of Health Insurance Plan** | **Date** | |
|  |  | |
| **Printed Name of Representative of Health Insurance Plan** | **Title of Representative of Health Insurance Plan** | |
| **STEP 2. Student submit this completed form to International Student Services** | | |