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.
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|  |
| **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** |