J HEALTH INSURANCE REQUIREMENT VERIFICATION

This form is to be completed by the insurance provider when a J-1 scholar and/or J-2 dependent is not covered by a Washington University Health Insurance plan.

Name of Insurance Provider: ________________________________

Name of Individual(s) Covered: ________________________________

Dates of Coverage: ________________________________

Any item not covered by the insurance plan listed above should be crossed out.


Health insurance must provide the following minimum coverage:
1. Medical benefits of at least $100,000 (US$) per accident or illness;
2. Repatriation of remains in the amount of $25,000 (US$);
3. Expenses associated with the medical evacuation of the exchange visitor (or accompanying spouse or dependent children) to his or her home country in the amount of $50,000 (US$);
4. A deductible not to exceed $500 per accident or illness.

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

Any policy, plan, or contract must, at minimum be:
1. Underwritten by an insurance corporation having an A.M. Best rating of “A−” or above; a McGraw Hill Financial/Standard & Poor's Claims-paying Ability rating of “A−” or above; a Weiss Research, Inc. rating of “B+” or above; a Fitch Ratings, Inc. rating of “A−” or above; a Moody's Investor Services rating of “A3” or above; or such other rating as the Department of State 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 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.

I confirm that the insurance plan the above individual(s) is enrolled in meets or exceeds the minimum standards of the J Exchange Visitor Program as outlined above.

__________________________________________  ________________________________  ________________________________
Insurance Provider Representative Name & Title      Signature       Date

______________________________________________________________________________________________
Insurance Provider Address

______________________________________________________________________________________________
Insurance Provider Phone Number      Insurance Provider E-mail

Revised: 03/2019