PLEASE NOTE: THIS IS THE ONLY ACCEPTABLE FORM TO BE COMPLETELY FILLED OUT AND SIGNED BY PRIVATE INSURANCE COMPANIES. COPIES OF INSURANCE CARDS, INSURANCE POLICIES, ETC. WILL NOT BE ACCEPTED.

J-1 SCHOLAR INSURANCE COVERAGE EVALUATION FORM

NAME:_____ **DATE OF BIRTH:**_____

I certify that the above named individual and_____dependents have insurance coverage for the period _____through_____which meets or exceeds the following as well as all mandated benefits:
(mm/dd/yy) (mm/dd/yy)

Explain if NO:

- **Medical and accident coverage up to $100,000 per accident or illness. (NO AGGREGATE PLANS ACCEPTED)** ☐ **YES** ☐ **NO** _____
- **Maximum deductible of $500 per accident or illness. For multiple party plans $500 per person** ☐ **YES** ☐ **NO** _____
- **A representative who acts on behalf of insurance company/insurance plans: verification and/or processing ability. Must be able to conduct business and verify insurance coverage specifications in English. Plan MUST meet additional US federal government and US Department of State requirements (page 2 of form). Plans that are unable to be verified by the fifth business day will be denied. Scholar MAY NOT begin duties at LSU until insurance is verified and confirmed to meet all requirements.** ☐ **YES** ☐ **NO** _____
- **Policy must cover office visits for non-emergency and emergency visits (No emergency care only policies will be accepted)** ☐ **YES** ☐ **NO** _____
- **Minimum coverage of $25,000 repatriation of remains to home country. (pre-existing conditions related deaths (including suicide) must be covered; coverage must remain in force during entire stay in the U.S.)** ☐ **YES** ☐ **NO** _____
- **Minimum coverage of $50,000 medical evacuation of the exchange visitor to home country. (pre-existing conditions related illnesses must be covered; coverage must remain in force during entire stay in the U.S** ☐ **YES** ☐ **NO** _____

**Repatriation and medical evacuation coverage can be assessed separately for those J-1 scholars and dependents with policies lacking the repatriation/ medical evacuation coverage requirements for $45 per person + $15.00 processing fee per year*

NAME OF INSURANCE COMPANY: _____

AGENT REPRESENTING INSURANCE COMPANY: _____
Please print name

Signature of Agent_____**Date** _____

Email address of insurance agent:_____

Policy No. of insured:_____

Phone number for insurance company _____

Address for insurance company:_____

_____

I have enrolled in the above insurance program and verify that the above is true and accurate. I will continue to maintain this coverage and will notify your office of any changes and provide appropriate documents of any changes. I will provide documentation of continuation of the required coverage upon request for extension of J-1 status and/or expiration of the policy as stated above.

Signature of J-1 Scholar:_____**Date**_____

Any fraudulent or misrepresented information will result in an official misconduct report to the United States Department of State, possible termination of J status and/or deportation. Upon such findings, Louisiana State University will have no responsibility (legal or financial) to any health issues that apply to and have been incurred by me, including death. The ISO reserves the right to investigate the validity of private policy benefits in order to meet all listed requirements.

***ADDITIONAL POLICY FEDERAL/U.S. DEPARMTENT OF STATE REQUIREMENTS**

(1) Underwritten by an insurance corporation having an (please check all that apply. (*Please provide written evidence*.)

- **an A.M. Best rating of "A−" or above** **YES_____ NO_____**
- **a McGraw Hill Financial/Standard & Poor's Claims-paying Ability rating of "A−" or above** **YES_____ NO_____**
- **a Weiss Research, Inc. rating of "B + " or above** **YES_____ NO_____**
- **a Fitch Ratings, Inc. rating of "A−" or above** **YES_____ NO_____**
- **a Moody's Investor Services rating of "A3" or above** **YES_____ NO_____**

or

(2) Backed by the full faith and credit of the government of the exchange visitor's home country (please provide written evidence). **YES_____ NO_____**

(3) Co-insurance provisions will be permitted requiring exchange visitor to pay up to 25% of covered benefits per accident or illness (please check YES or NO) **YES_____ NO_____**

I certify that the insurance company meets the ADDITIONAL POLICY FEDERAL/U.S. DEPARTMENT OF STATE REQUIREMENTS stated above:

NAME OF INSURANCE COMPANY:_____

AGENT REPRESENTING INSURANCE COMPANY: _____

Please print name

SIGNATURE OF AGENT _____ Date:_____