

Health Insurance Information for J-1 Exchange Visitors

U.S. Department of State regulations require **all J-1 Exchange Visitors and their accompanying J-2 dependents** to have health insurance throughout the period of participation in the Exchange Visitor Program.

Minimum acceptable coverage would provide:

- medical benefits of at least \$50,000 per accident or illness
- repatriation of remains in the amount of \$7,500
- expenses associated with medical evacuation in the amount of \$10,000
- deductible not to exceed \$500 per accident or illness

Insurance coverage backed by the full faith and credit of the exchange visitor's home government also meets this requirement.

If you choose to buy your own health insurance coverage from another source, the insurance corporation underwriting the policy must have one of the following ratings:

- an A.M Best rating of "A-" or above
- an Insurance Solvency International, Ltd. (ISI) rating of "A-i" or above
- a Standard & Poor's Claimspaying Ability rating of "A-" or above
- a Weiss Research, Inc. rating of "B+" or above

HEALTH INSURANCE MEMO OF UNDERSTANDING for J-1 Exchange Visitors

Please complete and bring with you as you check in at the Office of International Student and Scholar Services (OISSS), upon your arrival at Brown University.

I understand that the U.S. Department of State requires all participants in Exchange Visitor Programs and their accompanying dependents to have health and accident insurance at the required minimum level of coverage.

I understand the cost of this insurance.

I understand that U.S. government regulations require the University to notify the U.S. Department of State and to terminate my J-1 status if they determine that my family members or I willfully fail to comply with the insurance requirements.

I understand the health insurance requirements, the costs involved, and the need to maintain the insurance throughout my stay at Brown University.

I understand that by signing this form I am not enrolled in health insurance automatically and that I am responsible for the purchase of such health insurance.

Name of Insurance Company: _____ **Policy Number:** _____

Phone number of insurance company: _____

Name _____

Signature _____

Date _____