



**Insurance Compliance Form  
For J-1 Scholars and J-2 Dependents**

**This Section is to be Completed by Scholar**

Last/Family Name  
First Name  
Street Address  
City State Zip code  
Country  
Phone Number Date of Birth

**Department of State Exchange Visitor Program Regulations requires Exchange Visitor Program participants including all J-1 and J-2 dependants (Short-term Scholars, Research Scholars, Professors, Specialists and Students, etc.) to have health insurance in effect for the entire duration of their J program. Failure to maintain health insurance is a violation of the J visa status and will subject all participants to departure from the United States. The Department of State regulations are located in the Code of Federal Regulations (22CFR, Part 62.14, available online at <http://www.exchanges.state.gov/jvisa>).**

**Instructions for Scholars**

In order to be considered properly insured, have this form completed by the health insurance company and return it or mail it to the address at the top of this form. If your policy does not meet these requirements, you will need to either purchase a supplemental plan that will add to the minimum required coverage, or purchase a new plan.

Scholar's Signature Date

**This Section is to be Completed by the Insurance Company**

Insurance Company Name  
Effective Date Termination Date\*  
*\*Only end of program and continuous coverage is accepted*  
U.S Claims Agent Address Phone

**Please Answer ALL Questions Below**

1. Medical benefit of \$ \_\_\_\_\_ per person per accident or illness. (Minimum U.S. \$50,000 required)
2. Deductible that does not exceed \$ \_\_\_\_\_ per accident or illness. (Requirement is U.S. \$500 or less)
3. Repatriation of remains in the amount of \$ \_\_\_\_\_. (Minimum U.S. \$7,500 required)
4. Medical evacuation expenses in the amount of \$ \_\_\_\_\_. (Minimum U.S. \$10,000 required)
5. Does insurance plan cover dependents at the required basic benefits listed on above items 1 through 4? Please check: YES  NO   
 If YES, please list dependents by writing their complete names below:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Insurance Company Representative**

*I attest to the fact that this insurance policy covers the above basic benefits. I have completed and verified the information on this form.*

Insurance Representative Name and Position (print)  
Stamp  
Signature Date