INSURANCE VERIFICATION FOR J-1/J-2 EXCHANGE VISITORS

Sufficient health insurance coverage is a requirement of all Exchange Visitors in J-1 or J-2 visa status. An Exchange Visitor who fails to maintain the sufficient insurance coverage will be in violation of federal immigration regulations; subject to termination from WMU J program as a participant; and must leave the U.S. immediately. The U.S. Department of State has established minimum insurance requirements for Exchange Visitors. You must sign this statement confirming compliance with the standards listed below:

1. Medical insurance must cover the entire period of participation in the Exchange Visitor program.

2. Medical benefits must provide a minimum of $50,000 per accident or illness.

3. Medical evacuation must be covered in the amount of $10,000, minimum (medical evacuation is emergency medical transportation to the home country.)

4. Repatriation must be covered in the amount of $7,500, minimum (in the unfortunate event of death, repatriation is the transportation of remains back to the home country.)

5. The deductible must not exceed $500 per accident or illness.

IMPORTANT NOTE: The WMU Employee Health Insurance Plan does NOT cover #3 and #4, so please purchase separate insurance to cover #3 and #4 and provide Immigration Services proof of purchase of Repatriation & Medical Evacuation coverage for you and your J-2 dependents. If not, Immigration Services will be forced to terminate your program.

I certify that the insurance policy I currently carry meets the above requirements for me and my J-2 dependents.

I also agree to maintain the required coverage for my entire program duration from dates _____________ to _____________, and I will renew my insurance to keep it in force at all times during the program dates, and I will provide proof of coverage to Immigration Services. I understand that if I fail to provide proof of current insurance coverage, Immigration Services will be forced to terminate my program.

Signature: ________________________  Date: _____________________
J-1’s Name: _______________________
Names of J-2 dependents covered by insurance:  _______________________________

For Immigration Services Use Only  Date Approved: ____________    By: ______________
* Attach a copy of valid health insurance card and Summary of Benefits showing adequate coverage.