UF International Center
UNIVERSITY of FLORIDA

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INSURANCE VERIFICATION
J-1 Exchange Visitor Program

Name	UFID	Date of Birth

The above named person has advised us that he/she has an insurance policy with your company. Please confirm that the policy covers all of the following U.S. federal requirements for J-1exchange visitors.

Program participants and their dependents are required to have medical insurance coverage with the following minimum benefits [22 CFR 62.14]**.**

No international participant in the J-1 Exchange Visitor Program shall be permitted to enroll or continue in the program at the University of Florida without demonstrating that the J-1 exchange visitor has adequate medical insurance coverage for illness or accidental injury and which includes the following minimum requirements:

____ **1. Medical benefits of at least $100,000 per accident or illness.**

____ **2. Repatriation of remains in the amount of $25,000.**

____ **3. Expenses associated with the medical evacuation of the exchange visitor to his or her home country in the amount of $50,000.**

____ **4. A deductible not to exceed $500 per accident or illness (also may include a 6 month waiting period for pre-existing conditions and 25% co-payment).**

____ **5. The insurance policy secured to meet the benefits requirements must be underwritten by an insurance corporation with an A.M. Best rating of "A-" or above, an Insurance Solvency International, Ltd. (ISI) rating of "A-I" or above, a Standard and Poor's Claims Paying Ability rating of "A-" or above, or a Weiss Research, Inc. rating of B+ or above. Alternatively, the sponsor may ascertain that the participant's policy is backed by the full faith and credit of the government of the exchange visitor's home country.**

____ **6. Policy must not unreasonably exclude coverage for perils inherent to the exchange visitor's program of participation.**

____ **7. Claims must be paid in U.S. dollars payable on a U.S. financial institution.**

I hear by confirm that_____does meet all the above requirements (1-7)
Insurance Company/Policy number

for the period from (start date)_____ to_____(end date).

Printed Name of Insurance Representative (IR) _____

IR Signature _____ Date _____

Company Address _____

_____

Phone Number_____ Fax Number _____

Required: Company Stamp/Seal