NYU Office of Global Services

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J-1 SCHOLAR HEALTH INSURANCE ACKNOWLEDGMENT & INSURANCE PROVIDER CERTIFICATION FORM

Section A must be completed by J-1 Scholar

A. _____ _____
Last Name, First Name *Birthdate (mm/dd/yyyy)*

I acknowledge that New York University (NYU) policy and the code of federal regulations require J-1 exchange visitors (as well as their J-2 dependents) to have health insurance that meets specified minimum requirements. Coverage must run for the entire duration of the my program in the US. Failure to maintain adequate insurance coverage is a violation of US government regulations that will result in immediate termination of my J-1 status.

I acknowledge that it is my responsibility to choose my own health insurance carrier and to obtain the carrier's certification that the plan meets specific minimum coverage requirements. I further acknowledge my responsibility to maintain insurance coverage and to submit this form at each and every renewal or change of carrier. Further, I understand that the required minimum coverage levels may change each year and that I am responsible for updating my insurance in keeping with the stated requirements. I certify that I am covered by health insurance that meets all requirements described below. I promise to maintain this level of health insurance throughout the time I am in J-1 status. I acknowledge and agree that NYU is not responsible for my health insurance or medical expenses. If I have J-2 dependents, all of my certifications, promises, acknowledgments, and agreements extend to my dependents as well as myself.

_____ _____ _____
J-1 Exchange Visitor Exchange *Date* *Email address*

Section B must be completed by the health insurance company representative:

B. Name(s) of insured individual(s): ***Print Full Name***

_____ _____

_____ _____

Insurance Carrier: _____

Policy Number/Plan Type: _____

Dates:*_____ *to*_____ *mm/dd/yyyy mm/dd/yyyy*

*Federal regulations require that all J-1 exchange visitors and J-2 dependents have health insurance that meets specified minimum requirements throughout the duration of your program

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The plan/policy must meet ALL of the following minimum coverage requirements (all amounts are in USD).
Agent: initial each line that meets coverage requirements.

- ☐ Medical benefit of at least $100,000 per person per accident or illness
- ☐ Deductible that does not exceed $500 per accident or illness
- ☐ J patient cannot be required to pay more to exceed 25% medical costs
- ☐ Minimum medical evacuation expenses in the amount of $50,000
- ☐ Minimum repatriation of remains in the amount of $25,000

In addition, your health insurance policy must be underwritten by a corporation having one of the following:
Agent: Please select all that apply

- ☐ An A.M. Best rating of "A-" or above
- ☐ A McGraw Hill Financial/Standard & Poor A- rating or above for claims-paying ability
- ☐ A Weiss Research, Inc. rating of "B+" or above
- ☐ A Fitch Ratings, Inc. rating of "A-" or above
- ☐ A Moody's Investor Services rating of "A3" or above
- ☐ Is backed by the "full faith and credit" of the exchange visitor's home country
- ☐ Is part of a health benefits program offered on a group basis to employees or enrolled students by a designated sponsor

I certify that the minimum coverage requirements stated above are provided by this policy/plan. I am qualified to make this determination as an authorized agent/employee of the above insurance provider.

_____ _____

Print Name *Contact Information (email and/or phone number)*

_____

Company/Agency

_____ _____ _____

Signature *Title* *Date*