BSMP Student Health Insurance Confirmation

Purpose: The purpose of this form is to ensure you are properly enrolled in a health insurance plan that meets or exceeds J-1 visa regulations (see below) and can receive appropriate medical care when needed. If your academic host institution is unable to provide you with a health insurance plan that meets these minimum requirements or no coverage at all, IIE will enroll you in its private health plan. This is a benefit of your Brazil Scientific Mobility Program (BSMP) scholarship.

J-1 Visa Health Insurance Coverage Requirements:

1. Medical benefits of at least $50,000 per accident or illness;
2. Repatriation of remains in the amount of $7,500;
3. Expenses associated with medical evacuation of the exchange visitor to his or her home country in the amount of $10,000
4. A deductible not to exceed $500 per accident or illness.
5. An insurance policy secured to fulfill the requirements of this section:
   a. May require a waiting period for pre-existing conditions which is reasonable as determined by current industry standards;
   b. May include provision for co-insurance under the terms of which the exchange visitor may be required to pay up to 25 percent of the covered benefits per accident or illness;
6. Policy must be underwritten by an insurance corporation having an A.M. Best rating of "A-" or have; an Insurance Solvency International, Ltd. (ISI) rating of "A-" or above; a Weiss Research, Inc. rating of B+ or above.

Assignment: Please complete the fields below in their entirety and return a completed form to bswbinsurance@iie.org within ten (10) days. **If you are unable to fill out this form on your own,** we encourage you to print out this form and visit your academic host institution's health center/office to ask for guidance.

A. Personal Information:

Last Name:_____ First/Second Name:_____

IIE ID Number or SEVIS N number: _____ Current Telephone Number: _____

Name of U.S. Academic Host Institution: _____

B. Health Insurance Information:

Name of Health Insurance Provider: _____

Coverage Start Date: _____ *(month/day/year)* Coverage End Date:_____ *(month/day/year)*

- ✓ *If your health insurance coverage is only for the current semester, will your coverage be automatically renewed? Circle one.* Yes No
- ✓ *My health insurance provider or university is able to invoice IIE directly, and I have verified this information with my academic host institution's health center/office. Circle one.* Yes No
- ✓ *My current health insurance plan meets or exceeds the J-1 Visa requirements outlined above, and I have verified this information with my academic host institution's health center/office. Circle one.* Yes No

By singing below I hereby certify that the above information is true and correct. If I have answered "**no**" to any of the following questions above, I understand that upon submitting this form, IIE will enroll me in its private health insurance plan. I also understand that IIE has full discretion to cancel my health insurance coverage at any point of my program.

_____ _____

Signature Date *(month/day/year)*

Email completed, signed form to bswbinsurance@iie.org. In the subject line please write: Full Name / IIE ID Number / U.S. Academic Host Institution / Health Insurance Confirmation