# 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:**

- Medical benefits of at least $50,000 per accident or illness;
- Repatriation of remains in the amount of $7,500;
- Expenses associated with medical evacuation of the exchange visitor to his or her home country in the amount of $10,000
- A deductible not to exceed $500 per accident or illness.

**An insurance policy secured to fulfill the requirements of this section:**

- May require a waiting period for pre-existing conditions which is reasonable as determined by current industry standards;
- 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;
- 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.

**Instructions:**
Please complete the fields below in their entirety and submit the completed form to your BSMP Grantee Service Portal (https://mycusthelp.info/IIE/_cs/Login.aspx) as soon as possible. You must select "**HEALTH INSURANCE**" as the Document Category. **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 or your international student advisor for guidance.

**Personal Information:**

Full Name: _____ IIE ID Number: _____

U.S. Academic Host Institution: _____

**Health Insurance Information:**

Name of Health Insurance Provider: _____

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

****NOTE:** If your coverage expires before the program end date on your Terms of Appointment, you are responsible for ensuring your U.S. academic host institution or IIE has enrolled you in additional health insurance coverage for remainder of your program (until the end date of your program) that meets the J-1 regulations list above.

**Terms and Conditions:**

- I confirm that my health insurance plan meets the J-1 Visa Health Insurance Coverage Requirements listed above.
- I understand that I must be enrolled in an adequate health insurance plan throughout the duration of my authorized program.
- I confirm that I will inform IIE if my health insurance coverage ceases or if there is any change whatsoever.
- I confirm that I have read my health insurance plan's summary of benefits and I am fully responsible for any out-of-pocket expenses such as co-pays, deductibles, co-insurance, etc. or services not covered by my health insurance plan. I understand that these expenses are not covered by my BSMP scholarship, IIE or my U.S. host institution.

*By signing below I hereby certify that the above information is true and correct. I have also read and understand the above terms and conditions. Furthermore, I understand it is my responsibility to ensure I am enrolled in an appropriate plan that meets J-1 visa requirements for the duration of my authorized program and that IIE has full discretion to end my visa sponsorship should I misrepresent or fail to inform IIE of any change to my health insurance in any way.*

_____ _____
Student Signature Date *(month/day/year)*

_____ _____
Name of Host Institution Official Signature of Host Institution Official