# EXCHANGE VISITOR (J VISA) HEALTH INSURANCE

## STATEMENT OF COMPLIANCE

I have been informed that medical insurance coverage is mandatory for the duration of my J-1 program in the United States. I understand the medical insurance requirements as stipulated by the federal regulations as announced by the United States Department of State through 22 C.F.R. 62.14.

I certify that I have enrolled in – or will immediately enroll in – an insurance plan or contribution to plans that meet all the U.S. Department of State specifications. I further certify that I have enrolled all my J-2 dependents or will enroll any J-2 dependents who may join me later. I am aware that my family and I must maintain qualifying health insurance that meets all these requirements for the duration of our J program.

I also understand that if I willfully fail to obtain and maintain adequate medical insurance, the University of Massachusetts Dartmouth may terminate my participation in its Exchange Visitor Program and may notify the U.S. Department of State that my program has been terminated. Such action will result in the loss of my lawful immigration status in the United States.

**Signature:**_____ **Date:**_____

## POLICY DISCLOSURE

**Name** (please print):_____ **UMD ID #:**_____
(Family) (First) (Middle I)

☐ I am a degree seeking student and I have purchased health insurance from UMass Dartmouth

☐ I am a non-degree seeking student and have purchased health insurance. Please provide information below.

☐ I am scholar and have purchased health insurance. Please provide information below.

**Insurance Company Name:** _____
**Company Location (city, state):** _____**Telephone #**_____
**Insurance Policy Number:** _____
**Coverage Details:** Effective From: _____ To: _____ or □ Indefinite (DOS)

Please list all family members covered by this insurance policy (Last Name, First Name):
1. _____
2. _____
3. _____
4. _____

☐ The above policy includes Medical Evacuation & Repatriation of Remains for me and my family members (if applicable).

☐ I have purchased a supplemental policy to cover Medical Evacuation & Repatriation of Remains for me and my family members (if applicable).

***I certify that the above information is true and accurate to the best of my knowledge.***

**Signature:**_____ **Date:**_____

Please return the completed and signed form to:
University of Massachusetts Dartmouth
International Student & Scholar Center
285 Old Westport Road, N. Dartmouth, MA 02747
Phone: (508) 910-6633 Fax:(508) 910-6588 email intl_office@umassd.edu