UNIVERSITY OF NORTH FLORIDA EXCHANGE VISITOR PROGRAM
SICKNESS AND ACCIDENT INSURANCE VERIFICATION

Health and Accident Insurance is mandatory for all J-1 Exchange Visitors and any J-2 family members during their stay at the University of North Florida. This is a requirement of the U.S. Department of State. This *Sickness and Accident Insurance Verification* form is used by the Exchange Visitor to provide proof that he or she is insured by the home government or by a company within the country of his or her legal residence. The named Exchange Visitor upon his or her arrival to the University of North Florida must present proof of insurance coverage to the UNF International Center. ***The insurance policy must cover the entire time period for which the DS-2019 Form is valid.***

Exchange Visitor Name: _____

Name of Insurance Provider: _____

I authorize my insurance provider to release the following information to the University of North Florida.

Visitor Signature: _____ Date: _____

TO BE COMPLETED BY INSURANCE PROVIDER:
Please verify that the insurance policy you have issued to the above named person meets or exceeds the following 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/her home country in the amount of $50,000;

4. A deductible not to exceed $500 per accident or illness (may require a waiting period for pre-existing conditions which is reasonable as determined by current industry standards; also may include provision for co-insurance under the terms of which the exchange visitor may be required to pay up to 25% of the covered benefits per accident or illness);

5. Shall not unreasonably exclude coverage for perils inherent to the activities of the Exchange Program in which the Exchange Visitor participates;

6. Any policy, plan, or contract secured to fill the above requirements must, at a minimum, be:

(A) Underwritten by an insurance corporation having an A.M. Best rating of "A-" or above, an Insurance Solvency International, Ltd. (ISI) rating of "A-i" or above, a Standard & Poor's Claims-paying Ability rating of "A-" or above, or a Weiss Research, Inc. rating of B+ or above; or

(B) Backed by the full faith and credit of the government of the exchange visitor's home country; or

(C) Part of a health benefits program offered on a group basis to employees or enrolled students by a designated sponsor; or

(D) Offered through or underwritten by a federally qualified Health Maintenance Organization (HMO) or eligible Competitive Medical Plan (CMP) as determined by the Health Care Financing Administration of the U.S. Department of Health and Human Services.

Please also indicate if **family members** are covered: YES ☐ / NO ☐

On behalf of the above named insurance company, I hereby certify that the insurance indicated covers all of the above requirements. In addition, I certify that the insurance coverage is for the time period listed below, and I have indicated above whether the coverage includes family members or not.

Name Insurance Company Official (print): _____
Dates of Effective Coverage: _____
Authorized Signature of Insurance Company Official: _____ Date: _____
Address: _____ City: _____
State: _____ Country: _____ ZIP: _____
Phone: _____ Fax: _____ E-mail: _____

Please mail or fax this form to your client or directly to the following:

Dr. Timothy H. Robinson
International Center, University of North Florida
1 UNF Drive
Jacksonville, FL 32224

For information E-MAIL: trobinso@unf.edu
TEL: 904-620-2657
FAX: 904-620-3925