LOUISIANA STATE UNIVERSITY
J-1 AND J-2 STUDENT INSURANCE COVERAGE EVALUATION FORM
SUMMER 2017

This form must be submitted (may be faxed at 225-578-1413 or e-mailed to jgoodlo@lsu.edu) to I.S. by Thursday, June 8, 2017 (absolute deadline date.)

NAME: ___________________________ D.O. B.:__________ LSU-ID: 89-__________________

Please Print (Last Name, First Name)

I certify that the above named individual and ______ dependents have insurance coverage for the period ______________ through ______________, which meets or exceeds the following as well as all mandated

(mm/dd/yy) (mm/dd/yy)

Benefits (coverage must be begin on or before June 5, 2017 and end on or after July 27, 2017 at a minimum for Summer 2017 semester):

Explain if NO:

- Medical and accident coverage up to $100,000 per accident or illness
  YES ______ NO ______
  (NO AGGREGATE PLANS ACCEPTED)

- Maximum deductible of $500. For multiple party plans $500 per person
  YES______ NO ______

- A U.S. representative “PHYSICALLY” located in the United States with a U.S. telephone number/contact who acts on behalf of insurance company/insurance plans: verification and processing ability
  YES ______ NO ______

- Policy must cover office visits for non-emergency and emergency visits (No emergency care only policies will be accepted) *SEE ADDITIONAL POLICY REQUIREMENTS ON PAGE 2
  YES______ NO ______

- Maternity visits must be paid as any other health condition.
  YES______ NO ______

NAME OF INSURANCE COMPANY: __________________________________________________________

AGENT REPRESENTING INSURANCE COMPANY: _____________________________________________

Signature of Agent ___________________________ Date:____________________________

Policy No. __________________________________

Phone number in United States ____________________________

Address in the United States ____________________________________________

______________________________________________________________________________

I have enrolled in the above insurance program and verify that the above is true and accurate. I will continue to maintain this coverage and will notify your office of any changes and provide appropriate documents of any changes. I will provide documentation of continuation of the required coverage upon expiration of the policy as stated above. Furthermore, I will provide the ISO with a new F-1 Insurance Coverage Evaluation Form each and every semester, regardless of the insurance coverage end dates stated on any previously submitted forms.

Signature of Student:____________________________ Date:____________________________

Any fraudulent or misrepresented information will result in an official student misconduct report to the LSU Dean of Students’ Office and possible University suspension. Upon such findings, Louisiana State University will have no responsibility (legal or financial) to any health issues that apply to and have been incurred by me, including death. The ISO reserves the right to investigate the validity of private policy benefits in order to meet all listed requirements.
*ADDITIONAL POLICY FEDERAL/U.S. DEPARTMENT OF STATE REQUIREMENTS

(1) 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, a Weiss Research, Inc. rating of B+ or above; or

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

(3) Co-insurance provisions will be permitted requiring exchange visitor to pay up to 25% of covered benefits per accident or illness

I certify that the insurance company meets the ADDITIONAL POLICY FEDERAL/U.S. DEPARTMENT OF STATE REQUIREMENTS stated above:

NAME OF INSURANCE COMPANY: ________________________________________________

AGENT REPRESENTING INSURANCE COMPANY: ________________________________

Please print name

SIGNATURE OF AGENT ___________________________ Date: ________________________