J-1 AND J-2 STUDENT INSURANCE COVERAGE EVALUATION FORM

This form must be submitted (may be faxed at 225-578-1413 or e-mailed to jgoodlo@lsu.edu) to International Services by Monday, January 23, 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 begin on or before January 11, 2017 and end on or after May 6, 2017 at minimum for the Spring 2017 semester):

Explain if NO:

- Medical and accident coverage up to $100,000 per accident or illness (*NO AGGREGATE PLANS ACCEPTED*) ☐ **YES____** ☐ **NO _____**

- 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) ☐ **YES____** ☐ **NO _____**
SEE ADDITIONAL POLICY REQUIREMENTS ON PAGE 2

- Maternity visits must be paid as any other health condition for all parties of plan. ☐ **YES_____ NO_____**

NAME OF INSURANCE COMPANY: _____

AGENT REPRESENTING INSURANCE COMPANY: _____
Please print name

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 J-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. DEPARMTENT OF STATE REQUIREIMENTS**

(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 visitors 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. DEPARMTENT OF STATE REQUIREIMENTS stated above:

NAME OF INSURANCE COMPANY:_____

AGENT REPRESENTING INSURANCE COMPANY: _____

Please print name

SIGNATURE OF AGENT _____ Date:_____