Federal regulations require all J-1 visa holders and their dependents to have medical insurance during the duration of their studies / research. Please complete this form so that we can report to the U.S government that you are in compliance with federal regulations regarding your J-1 visa status. Please submit this completed form to the Office of International Programs (OIP) in person or by email to OIP@utep.edu.

Your health insurance coverage period should be for the entire length of your DS-2019. If your program is for several years, you can provide health insurance coverage for one year increments.

Part I (To be completed by the J-1 visa holder)

Name: ______________________________________________________ UTEP ID #: ____________________________

Check one:

☐ Research Scholar/Professor
☐ Short term scholar
☐ Student Intern
☐ Student

Name of dependent(s) covered:
________________________________________________________ 
________________________________________________________ 
________________________________________________________________________________________________

Part II (To be completed by the insurance provider)

The above named J-1 exchange visitor and dependent(s) if applicable are covered by a medical insurance plan that meets or exceeds the following federal minimum requirements as mentioned below:

<table>
<thead>
<tr>
<th>Insurance Requirements for J1 and J2 visa holders</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Medical benefits of at least $100,000 per accident or illness</td>
</tr>
<tr>
<td>☐ Deductible does not exceed $500 per accident or illness</td>
</tr>
<tr>
<td>☐ Evacuation benefits of at least $50,000</td>
</tr>
<tr>
<td>☐ Repatriation of remains benefits in the amount of $25,000</td>
</tr>
</tbody>
</table>

Name of Insurance Company: ___________________________ Policy Number: ___________________________

Beginning Date of Coverage: ___________________________ End Date of Coverage: ___________________________ (Month/Day/Year) (Month/Day/Year)

Insurance Representative (printed name): ___________________________

Signature: ______________________________________________________

Phone Number: ___________________________ Date: ___________________________