



EVALUATION & VERIFICATION OF HEALTH INSURANCE for international visiting scholars who purchase insurance outside of UC Berkeley

All non-immigrant visiting scholars and accompanying family members must be covered by a health insurance plan that meets UC Berkeley minimum requirements and USIA regulations for J-1 visa (federal guidelines effective 9/1/94).

- Please fill out this form **completely** so that we can determine whether or not your health plan meets the minimum requirements.
- **Attach a copy of your coverage booklet (with English translation) and/or a letter from your insurance company.** Your insurance will not be evaluated unless the information is complete and written evidence from your insurance company is available for verification.
- The dates of coverage must parallel your University appointment; your J-1 visa is invalid without proof of health insurance.

PART 1: SCHOLAR COMPLETES AND RETURNS TO DEPARTMENT WITH PROOF OF INSURANCE

Scholar's name _____ Home country _____
(Last) (First)

Family members here with you: Spouse _____ Children _____ Family included in this plan: yes _____ no _____

Name of Insurance Company _____ Insurance Office/
Contact in U.S. _____

Address _____ U.S. Address _____

Telephone _____ U.S. Telephone _____

Period of Coverage: from _____ to _____ (must parallel visiting dates)
month / day / year month / day / year

• Required medical benefits coverage of at least \$50,000 per accident or illness.	Total Limit of Coverage for any sickness or accident (in U.S. dollars): _____
• Deductible is not to exceed \$500 per year.	Deductible: _____
• Maximum 25% co-insurance/co-payment provision for covered services at customary & reasonable charges in U.S. dollars, <u>not</u> equivalent cost for services in home country.	Percentage of payment for: Doctor _____ Hospital _____
• Required \$10,000 minimum coverage for expenses associated with the medical evacuation to scholar's home country.	Medical Evacuation Limits: _____
• Required \$7,500 minimum coverage for repatriation of remains to home country.	Repatriation Limits _____
• Required coverage for pre-existing conditions after a 12-month waiting period.	Pre-existing conditions covered: yes _____ no _____

The above information is correct and true to the best of my knowledge and I accept the responsibility for maintaining adequate health insurance for me and my family during my stay at the University of California at Berkeley.

Scholar's signature _____ Date _____

PART 2: FOR DEPARTMENTS TO COMPLETE

Send a copy of this completed form to: International Health Advisor, UHS-Tang Center, mail code #4320, or fax to 642-9119.

Verified by _____ Dept. _____ Phone # _____
AA's Name (Please Print)

Signature _____ Date _____

A COPY OF THIS FORM SHOULD BE KEPT WITH THE DEPARTMENT RECORDS.