



**OFFICE OF INTERNATIONAL STUDENTS AND SCHOLARS**

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**HEALTH INSURANCE REQUIREMENT**

I have been informed that medical insurance coverage is mandatory for the duration of my J program in the United States. I understand the medical insurance requirements as stipulated by the Federal regulations promulgated by the United States Information Agency (USIA).

I certify that I have enrolled in an insurance plan or combination of plans that meet all the USIA specifications. I further certify that I have enrolled all my J-2 dependents or will enroll any J-2 dependents who may join me later. I am aware that my family and I must maintain qualifying health insurance which meets all these requirements for the duration of our J program.

I also understand that if I willfully fail to obtain and maintain adequate medical insurance, the University of Rhode Island may terminate my participation in its Exchange Visitor Program and may notify the USIA that my program has been terminated. Such action will result in the loss of my legal immigration status in the United States.

Last Name	
First Name	
Middle Name	
Social Security Number	
Status	
<b>MEDICAL INSURANCE POLICY INFORMATION</b>	
Insurance Company Name	
Company Telephone	
Insurance Policy number	
Company Address	
Coverage Period	Beginning ____/____/____ Ending ____/____/____

**SIGNATURE** \_\_\_\_\_

**DATE:** \_\_\_\_/\_\_\_\_/\_\_\_\_