**J-VISA STUDENT/SCHOLAR HEALTH PLAN WAIVER**

U.S. Department of State regulations require all J-1 students and scholars and J-2 dependents to have health insurance throughout the period of their stay. You may waive North Park University’s international health care plan if your coverage meets the following requirements:

|  |  |
| --- | --- |
| ITEM | MINIMUM |
| Medical benefits per accident or illness | $100,000 |
| Repatriation of remains in case of death | $25,000 |
| Medical evacuation to home country | $50,000 |
| Deductible per accident or illness (not to exceed $500) | $500 |

You, your spouse, and/or any dependent(s) may be subject to the requirements of the Affordable Care Act [22 CFR 62.14(a)]

* Covers pre-existing conditions after a reasonable waiting period
* May include provisions for coinsurance under the terms of which the Exchange

Visitor may be required to pay up to 25% of the covered benefits per accident or

Illness

* Does not exclude benefits for perils inherent to the activities of the Exchange Visitor’s program
* The plan must be:
	+ Underwritten by an insurance corporation having an A.M. Best rating of ‘‘A-’’ or above; a McGraw Hill Financial/Standard & Poor’s Claims paying Ability rating of ‘‘A-’’ or above; a Weiss Research, Inc. rating of ‘‘B+’’ or above; a Fitch Ratings, Inc. rating of ‘‘A-’’ or above; a Moody’s Investor Services rating of ‘‘A3’’ or above; or such other rating as the Department of State may from time to time specify;
	+ OR backed by the full faith and credit of the government of the exchange visitor’s home country;
	+ OR offered through or underwritten by a federally qualified Health Maintenance Organization or eligible Competitive Medical Plan as determined by the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services.

To waive your enrollment in North Park University’s international health plan submit this form to Michael Drake: medrake@northpark.edu or Tessa Zanoni: tzanoni@northpark.edu

In addition to the waiver form you must provide **written proof** that your coverage:

* Meets the above requirements
* Is effective from theProgram Start Date through the Program End Date listed on your Form DS-2019
* The explanations of benefits **must be translated into English**

If your coverage does not meet the above requirements, it will NOT be accepted.

|  |  |
| --- | --- |
| FULL NAME | NPU ID |
| EMAIL ADDRESS | PHONE NUMBER |
| INSURANCE COMPANY NAME | POLICY HOLDER’S NAME |
| POLICY NUMBER | GROUP NUMBER (if applicable) |
| INSURANCE CLAIM ADDRESS | INSURANCE CLAIM PHONE NUMBER |

I certify that the information I have provided is truthful and accurate. This authorization expires when I have completed by education at North Park University, when the selected semester is over, or when I cancel this waiver in writing. I understand that if the policy listed above does not meet the federal requirements, this waiver will not be accepted and I will be charged for the North Park University international health care plan.

SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- |
|  \_\_\_ Approved \_\_\_ Not Approved Date:  |