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Fermilab

Visa Office, International Services
HR Services, Workforce Development and Recruitment Section
(Fax) 630.840.3688 **(Phone) 630.840.3933 / 4203**
visaoffice@fnal.gov visas/fnal.gov

Medical Insurance Attestation for J-1 & J-2 Visa Holders

J-1 and J-2 Exchange Visitors to Fermilab must show that they are covered by appropriate medical insurance for the duration of their participation in the exchange visitor program, while they are in the U.S.
Fermilab Employees who receive health care benefits from Fermilab do NOT complete this Attestation. **All other J Visitors** MUST complete this.
All requested data must be provided or this form will be rejected. Please do not leave blanks! – indicate "no" or "not applicable"("n/a") when appropriate.

Section I: Foreign National Information *(To be completed by EACH family member.)*

Family Name: _____ Given Name: _____

Home Address: _____

_____

Fax Number or Email Address: _____

Name of Home Institution: _____

Name of Supervisor/Mentor at Fermilab: _____

Fermilab Division/Department Assigned To: _____

Signature of Foreign National: _____

Section II: Insurance Information *(To be completed by an insurance company representative.)*

Name of Insurance Company: _____

Policy Number: _____ Country: _____

Effective Date: _____ Expiration Date: _____

Regulations require that the insurance meets the following requirements:①

1. **Provides certain minimum coverage:** *(please specify the amount of coverage actually provided by your plan in the space provided)*
   - ✓ Policy Lifetime Limit Or Maximum Benefit Per Accident Or Illness: ..... US$_____ *(US$50,000 Minimum)* ***(AND)***
   - ✓ Repatriation Of Remains Back To Home Country②: ..... US$_____ *(US$7,500 Minimum)* ***(AND)***
   - ✓ Medical Evacuation Back To Home Country②: ..... US$_____ *(US$10,000 Minimum)* ***(AND)***
   - ✓ Deductible Or Excess Fee③: ..... US$_____; ***(AND)***
2. **Be provided by an insurance plan that satisfies one of the following conditions:**
   - ❍ Be backed by the full faith and credit of the government of _____ *(country name.*; **(OR)**
   - ❍ Be provided by a Federal, state or local government agency, state college or university, or public community college that is permitted by law to self-insure; **(OR)**
   - ❍ Be offered through, or underwritten by, a federally qualified Health Maintenance Organization (HMO) or eligible Competitive Medical Plan (CMP) ; **(OR)**
   - ❍ Have one of the following Ratings:
     - ☐ A.M. Best rating of "A-" or above.
     - ☐ Standard & Poor's Financial Strength Rating of "A-" or above.
     - ☐ Weiss Research, Inc. rating of "B+" or above.
     - ☐ INS. Solvency Intl., Ltd. rating of "A-I" or above.

① Policy benefits and limits must be stated in US dollars, and must convert, on the date of arrival at Fermilab, to exceed the minimums listed. Please allow for fluctuations in monetary exchange.
② Covered by Fermilab's Insurance Provider *③ Not To Exceed $500 USD Per Illness/Accident*

To Be Signed by Insurance Company Representative:

Signature of Representative: _____ Title: _____

Print Name: _____ Fax or Email: _____

Please return completed Attestation to the Visa Office.