LEWIS CLARK STATE COLLEGE

Medical Insurance Declaration – Form A (to be filled out by student)

First Name _____ **Last Name** _____

Warrior ID _____ **SEVIS ID** _____

Phone _____ **Email** _____

International students studying on a student visa are required to have sickness and accident insurance, including coverage for medical evacuation and repatriation of remains for the duration of study at LCSC. At a minimum, insurance must meet the U.S. Department of State requirements for J-1 visitors. At best, your insurance policy should meet the standards of the Affordable Care Act (ACA). For more information about the ACA go to http://obamacarefacts.com/affordablecareact-summary/

Make a check mark in the left column to indicate that your insurance meets the minimum requirements below. Attach a copy of your policy in English that confirms the information below or have your insurance company complete the back side of this form.

Check	Department of State Requirements	
	Benefit per accident or illness	At least $100,000
	Deductible per accident or illness	No more than $500
	Repatriation of remains	At least $25,000
	Medical evacuation	At least $50,000
	May include provisions for coinsurance (co-pay) up to 25% of the covered benefits per accident or illness	
	Does not exclude benefits for perils inherent to the activities of the program of study	
	Has a U.S. based claims office	
Check applicable box	Any insurance 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 student's home country; ☐ **OR** part of a health benefits program offered on a group basis to employees or enrolled students by a designated sponsor; ☐ **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.	

Name of Insurance company		Start and End date of Coverage	

By signing this form I understand, agree, and acknowledge that my insurance meets or exceeds the requirements listed above and that I will maintain insurance for the duration of my studies at LCSC. **Failure to provide this information by the published deadline (http://www.lcsc.edu/registrar/academic-calendar/) will result in dis-enrollment.**

☐ I have attached a copy of my policy.

Name (Printed): _____

Signature: _____ Date: _____

LEWIS CLARK STATE COLLEGE

Medical Insurance Declaration – Form B (to be filled out by insurance company)

By signing the box below, I authorize my insurance company to provide details about my insurance coverage and the start and end dates of coverage.

Student Name_____

Date of Birth_____

Signature_____ **Date**_____

To be completed by insurance carrier or company representative. Make a check mark in the left column to indicate that the insurance policy meets the minimum requirements below. Attach a copy of the policy in English that confirms the information below.

Check	Department of State Requirements	
☐	Benefit per accident or illness	At least $100,000
☐	Deductible per accident or illness	No more than $500
☐	Repatriation of remains	At least $25,000
☐	Medical evacuation	At least $50,000
☐	May include provisions for coinsurance (co-pay) up to 25% of the covered benefits per accident or illness	
☐	Does not exclude benefits for perils inherent to the activities of the program of study	
☐	Has a U.S. based claims office	
Check applicable box	Any insurance 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** part of a health benefits program offered on a group basis to employees or enrolled students by a designated sponsor; ☐ **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.	

Name of Insurance company		Start and End date of Coverage	
Phone		Email	

By signing this form I certify that the student listed above has purchased a medical insurance policy that meets or exceeds the coverage minimums above.

Name (Printed): _____Title_____

Signature: _____ Date: _____