THE UNIVERSITY OF MISSISSIPPI
MEDICAL CENTER

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CERTIFICATION OF HEALTH INSURANCE COVERAGE
EXCHANGE VISITOR PROGRAM

I understand that as a participant in the exchange visitor program of The University of Mississippi Medical Center I am required to obtain and maintain the following types and amounts of health insurance coverage for myself and my dependents.

1. A health insurance policy providing major medical coverage with a maximum of no less than $50,000 in benefits for each accident or illness. The deductible for this coverage can be no more than $500 per accident or injury.

2. In the event of my death or the death of my dependent(s), I must have coverage of at least $7,500 in benefits for transportation of remains to my home country.

3. In the event that I or my dependent(s) become seriously ill and must return to my home country, I must have coverage of at least $10,000 to cover the cost of transportation.

I certify that:

(a) My dependents (if applicable) ☐**are** ☐**are not** residing with me in the United States.

(b) I have obtained and continue to maintain major medical coverage (#1 above) and repatriation/medical evacuation coverage (#2 and #3 above) ☐**for myself** from the following providers:

☐ Major Medical Provider: _____ Expiration Date: _____

☐ Repatriation/Med. Evacuation Provider: _____ Expiration Date: _____

(c) I have obtained and continue to maintain major medical coverage (#1 above) and repatriation/medical evacuation coverage (# 2 and #3 above) ☐**for my dependents** from the following providers:

☐ Major Medical Provider: _____ Expiration Date: _____

☐ Repatriation/Med. Evacuation Provider: _____ Expiration Date: _____

I understand my responsibilities regarding health insurance coverage under the exchange visitor program and am aware that I can be terminated from the program for willfully failing to maintain the coverage.

Print Name: _____

Signature: _____

Date: _____