STATEMENT OF COMPLIANCE WITH THE INSURANCE REQUIREMENTS OF THE
EXCHANGE VISITOR PROGRAM

Exchange visitors under the sponsorship of the University of Oregon’s Exchange Visitor Program
must complete and sign this statement of compliance with the insurance requirements of the
Exchange Visitor Program. Please return this form to International Affairs at your initial check-in or
not later than 30 days after your DS-2019 begin date or extension of stay. This form must be
accompanied by readable proof of insurance coverage, in English. Failure to comply with the
insurance requirements may result in the termination of an Exchange Visitor’s program.

I understand and acknowledge that:
• In order to maintain eligibility for J-1 Exchange Visitor Status under the sponsorship of the
University of Oregon’s Exchange Visitor Program, I must maintain insurance coverage for
myself and any dependents who hold J-2 status;
• This coverage must provide medical benefits of at least $50,000 per accident or illness;
repatriation of remains in the amount of $7,500; expenses associated with medical
evacuation in the amount of $10,000; and a deductible not to exceed $500 per accident or
illness;
• The policy must remain in effect at all times during my participation in the exchange visitor
program and if for any reason my coverage lapses I must immediately obtain other
comparable insurance coverage;
• If I fail to comply with these insurance requirements my participation in the University of
Oregon’s Exchange Visitor Program must be terminated.

I agree to these conditions and verify that I am currently insured at levels that meet or exceed the
insurance requirements outlined above. For purposes of documentation, a copy of my insurance
policy is attached.

Family Name: __________________________ First Name: __________________________
Department: __________________________

My DS-2019 covers the period: ______/_____/______ to ______/_____/______
MM DD YYYY MM DD YYYY

Insurance Company Name: ______________________________________________________
Insurance Company Address: _____________________________________________________
Insurance Company Telephone Number: ___________________________________________

Policy/Group #: __________________________

Policy Effective Dates: ______/_____/______ to ______/_____/______
MM DD YYYY MM DD YYYY

Full names of all J-2 dependents covered by this insurance policy:
_____________________________________________________________________________

Exchange Visitor’s Signature: __________________________ Date: ______/_____/______
MM DD YYYY

RETURN THIS FORM TO:
International Affairs
Room 333 Oregon Hall/5209 University of Oregon, Eugene, OR, 97403/541-346-3206

(Over)