



TRAINEE PROGRAM

The Swedish-American Chambers of Commerce of the United States of America, Inc.

INSURANCE VERIFICATION FORM

I am aware that U.S. Federal Regulations state that all interns/trainees (and accompanying dependents) who enter the United States under the auspices of SACC-USA must be covered by health and accident insurance for the **entire duration of their training program**. I hereby certify that:

- The insurance policy I have chosen meets or exceeds the coverage limits set by U.S. Federal Regulations:

Medical and Accident:	\$50,000 per illness/accident
Medical Evacuation:	\$10,000
Repatriation:	\$7,500

- I have read the insurance information provided by SACC-USA and I am aware that if I willfully fail to carry health insurance for myself or my dependents, or if I misrepresent my insurance coverage, then SACC-USA must terminate my program.
- This coverage will be in effect for the entire duration of my training in the United States. If this policy is not valid through the entire duration of the training period, I certify that it can and will be renewed.
- I have attached hereto submission of my policy that identifies my (and my dependents, if applicable) name, policy number, and duration of coverage.

Name of insurance company:

Street:

City:

Zip code:

Country:

Telephone:

Fax:

E-Mail:

Policy number:

Dates of coverage:

(mm/dd/yyyy- mm/dd/yyyy)

Signature: _____ Date: *(mm/dd/yyyy)*

SACC-USA

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