

## STATEMENT OF INSURANCE COVERAGE

It is a requirement of all Cultural Vistas programs that participants be covered by health insurance for the entire duration of their stay in the host country. To ensure that all participants are covered for medical evacuation and repatriation, Cultural Vistas also requires that all participants in this program purchase MER insurance coverage at \$10 per month.

**Please complete sections 1 and 2 below, sign and date this statement, and return it to us.**

**As a participant in a program in Switzerland sponsored by Cultural Vistas:**

### Section 1

I authorize Cultural Vistas to enroll me in MER insurance for the dates below.

(Please feel free to request coverage information in advance.)

**Coverage Dates:**

A check payable to "Cultural Vistas" in the amount of \$10 x no. of program months is enclosed.

I would like to pay with a credit or debit card. Please email me an invoice for the coverage dates above, so that I can submit my payment online.

### Section 2

#### Option 1

My Swiss employer will enroll me in health insurance, as stated in my employment contract.

#### Option 2

I hereby verify that: (1) I either have now, or will purchase before my departure, insurance that covers me during the period of my participation in the Cultural Vistas Program, (2) I have verified with my insurance company listed below that this coverage will be accepted while I am in Switzerland, and (3) I have verified that my coverage is in compliance with Swiss federal and local laws regulating health insurance coverage for foreign trainees. My insurance policy carrier is:

**Insurance Name:**

**Address:**

**Telephone:**

**Policy No.:**

I further acknowledge that I am responsible for any medical costs I incur that are not explicitly covered by the insurance required for the program, including, but not limited to, prescription medications, pre-natal care, physical therapy, any pre-existing conditions, and psychological counseling. Cultural Vistas bears no liability for any financial obligations that I may incur as a result of expenses not covered by the insurance required by the program.

**Signature:**

**Name:**

**Date:**