UNIVERSITY OF FLORIDA COLLEGE OF MEDICINE

2006-2007 HEALTH INSURANCE VERIFICATION

INSTRUCTIONS TO STUDENT: Print as much information in **Parts I and II** as you are able to complete. **Then forward the form to your health insurance provider.**

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PART I: STUDENT INFORMATION, Please Print:

Name:____

Home Phone:(____)__________________________ Date of Birth:_________________________________

UF ID Number____________________________ Medical School Year: 1st 2nd 3rd 4th (circle one)

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PART II: POLICY INFORMATION, *Please Print*:

Insurance Company:____

Telephone Number of Insurance Company:____

Contact Person (if relevant):____

Name of Policy Holder:___________________________ Policy Number:______________________________

Relationship to Student:_________________________ Group Number:_______________________________

Effective Date:__________________________________ End Date (if applicable):_____________________

Conditions Under Which Insurance Expires (check all that apply):

_______Age Limit (specify):
_______Marriage
_______Lack of Payment Premium
_______Termination of Employment of Policy Holder
_______Lack of Full-time Student Status

Payment Schedule: _____Monthly; _______Quarterly; _______Semi-Annually; _______ Annually

Other Conditions (please specify, use reverse side if necessary):

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PART III: INSURANCE VERIFICATION OF POLICY INFORMATION IN PART II, ABOVE:
(Must be completed by Insurance Company)

Name:____________________________________ Title:____________________________________

Signature:_________________________________ Date:_____________ Phone:_________________

MAIL or **FAX** to:

Student Affairs and Registration
University of Florida
College of Medicine
PO Box 100216
Gainesville, Florida 32610-0216

Telephone: 352/392-3071
Fax: 352/846-0622

ALL MEDICAL STUDENTS ARE REQUIRED TO SUBMIT THIS FORM EVERY FALL SEMESTER