

UNIVERSITY OF FLORIDA COLLEGE OF MEDICINE

2009-2010 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.

\*\*\*\*\*

PART I: STUDENT INFORMATION, Please Print:

Name: \_\_\_\_\_

Home Phone:( ) \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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

\*\*\*\*\*

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): Termination of Employment of Policy Holder
Marriage Lack of Full-time Student Status
Lack of Payment Premium

Payment Schedule: Monthly; Quarterly; Semi-Annually; Annually

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

\_\_\_\_\_

\*\*\*\*\*

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 Telephone: (352) 273-7971
College of Medicine Fax: (352) 846-0622
PO Box 100216
Gainesville, Florida 32610-0216

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