UNIVERSITY OF FLORIDA COLLEGE OF MEDICINE
2019-2020 Health Insurance Verification

Instructions to Students: Print as much information in Parts I and II as you are able to complete. Please attach letter from your insurance company indicating your coverage, **with this completed form.**

Part I: Student Information. Please Print:

Name: _____

Home Phone: ( ) _____ Date of Birth: _____

UF ID Number _____ Medical School Year (**Class of?**): _____

Part II: Policy Information. Please Print:

Insurance Company: _____

Telephone Number of Insurance Company: _____

Contact Person (if relevant): _____

Name of Policy Holder: _____ Policy #: _____

Relationship to Student: _____ Group #: _____

Effective Date: _____ End Date (if applicable): _____

Return completed forms to: Student Affairs & Registration
University of Florida COM
PO Box 100216
Gainesville FL 32610-0216

Or Fax: **(352) 273-7536**

ALL medical students are required to submit this form every Fall semester.