UNIVERSITY OF FLORIDA COLLEGE OF MEDICINE
2021-2022 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 along **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 COMPO
Box 100216
Gainesville FL 32610-0216

Fax: **(352) 627-4260**
Email: **vbusseno@ufl.edu**

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