UF | UNIVERSITY of FLORIDA

College of Medicine
Office of Student Affairs

PO Box 100216
Gainesville, FL 32610-0216
352-273-7971

HEALTH INSURANCE VERIFICATION

Part I: Student Information

Name: ____

Date of Birth: ____

Phone: ____

UF ID Number: ____

Medical School Year (Class of?): _____________________________________

Part II: Policy Information. Please Print:

Insurance Company: ____

Phone Number of Insurance Company: _________________________________

Contact Person (if relevant): ____

Name of Policy Holder: Policy #: _____________________________________

Relationship to Student: Group #: ____________________________________

Effective Date: ____

End Date (if applicable): ____

ATTACH YOUR INSURANCE CARD TO THIS COMPLETED FORM.
ALL MEDICAL STUDENTS ARE REQUIRED TO SUBMIT THIS FORM EVERY FALL SEMESTER.

Return completed forms to:
Email: atiak@ufl.edu
Mail: UF COM Student Affairs - PO Box 100216, Gainesville FL 32610-0216
Fax: (352) 627-4260

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