

Insurance Verification Form

PLEASE PRINT

_____ Last Name	_____ First Name	_____ Middle Name or Initial
_____ Social Security Number		_____ Phone Number
_____ College		

I hereby attest to the following:

1. I do not wish to enroll in the UT Health Science Center Health Insurance plan.
2. I currently possess equivalent health insurance to that which is provided in the UT Health Science Center plan.
3. I understand that I am required to have equivalent health insurance throughout my complete student career at the UT Health Science Center.
4. I understand that to falsify this information is a violation of the Honor Code and of The Ethical and Professional Behavior expected of the UT Health Science Center students and that falsification of the information will result in appropriate disciplinary actions.
5. I understand that my enrollment in an equivalent plan is required by the end of the first week of classes, which I attend at the UT Health Science Center.
6. I understand that I am responsible for all financial liabilities associated with my health care.

Signature

Date

Please provide the name of the insurance company and program in which you are enrolled as well as its mailing address and phone number. (Please print.)

**Attach a copy of your proof of insurance (such as a photocopy of your insurance card).
This form must be completed and submitted
with insurance information every semester of enrollment at UTHSC.**

Mail to: Office of Student Affairs
800 Madison Avenue, Rm. 300
Memphis, TN 38163

Phone: (901) 448-4860
Fax: (901) 448-7585
E-mail: lroemer@utmem.edu