

LURLEEN B. WALLACE COLLEGE OF NURSING AND HEALTH SCIENCES

HEALTH INSURANCE FORM

Verification of Medical Insurance for _____ (Semester) _____ (Year)

Student's Name (print): _____

Insurance Company: _____

Name of Insured (name on card): _____

Contract #: _____

Group #: _____

Effective date: _____

I certify that the above information is accurate and true. I am fully covered with medical insurance that extends through the end of this semester. If this insurance status changes before the end of the semester, I will notify my course coordinator and will purchase additional insurance immediately. **I understand I cannot attend clinicals unless I am covered with medical insurance.**

Signature of student: _____

Date: _____ Faculty's Initial: _____