LURLEEN B. WALLCE COLLEGE OF NURSING
HEALTH INSURANCE VERIFICATION FORM

PLEASE SEND A COPY OF YOUR HEALTH INSURANCE CARD ALONG WITH THIS FORM. YOU MAY FAX IT TO 256-782-5406.

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: _____