

INSURANCE INFORMATION

(Do not use if you have the UNL Healthy Option Student Plan – see other form)

PLEASE PRINT CLEARLY AND COMPLETE ALL INFORMATION

Name _____		Social Security # _____
Local Address/City/State/Zip _____		
Date of Birth _____	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship to Insurance Policyholder <input type="checkbox"/> self <input type="checkbox"/> child <input type="checkbox"/> spouse <input type="checkbox"/> other
Local/Cell Telephone _____	Full Time Student/Employee <input type="checkbox"/> Yes <input type="checkbox"/> No	School Name <input type="checkbox"/> UNL <input type="checkbox"/> UNK <input type="checkbox"/> UNMC <input type="checkbox"/> UNO <input type="checkbox"/> Other _____

IN CASE OF EMERGENCY PLEASE CONTACT:

Name _____ Phone # (____) _____

Relationship _____

Address/City/State/Zip _____

INSURANCE COMPANY

Insurance Company Name _____

Insurance Company Address _____

City _____ State _____ Zip _____

INSURANCE POLICY HOLDER INFORMATION

Name: Last Name, First Name, Middle Initial (Parent/Spouse/Self) _____

Policyholder's Gender

Male Female

Mailing Address of Policyholder

Address _____

City _____ State _____ Zip _____

Country _____

Policyholder's Social Security Number _____

Policyholder's Date of Birth _____

Policyholder's Employer Name _____

Policy # / ID _____

Group # / Plan _____

ANNUAL AUTHORIZATION

I am responsible for all charges incurred during my visit to the University Health Center.

X _____
Patient Signature _____ Date _____

I authorize UHC to release necessary information to my insurance company.

X _____
Patient Signature _____ Date _____