UNL HEALTHY OPTION STUDENT PLAN
INSURANCE INFORMATION

PLEASE PRINT CLEARLY AND COMPLETE ALL INFORMATION

Name		Social Security #
Local Address/City/State/Zip		
Date of Birth	Gender ☐ Male ☐ Female	UNL ID#
Local/Cell Telephone	Full Time Student/Employee ☐ Yes ☐ No	School Name ☐ UNL ☐ UNK ☐ UNMC ☐ UNO ☐ Other ____________________

IN CASE OF EMERGENCY PLEASE CONTACT:

Name ____ Phone # (________)__________________________

Relationship ____

Address/City/State/Zip____

INSURANCE COMPANY: Aetna Student Health

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