Student Proof of Health Insurance

ALL INFORMATION IS REQUIRED

Today's Date: (yyyy, mm, dd) ____________________

Student Name

(first name, complete middle name, last name): ____________________

Insurance Provider: ____________________

Member, Enrollee or Primary Holder: ____________________

Group # or Member ID: ____________________

Member/Provider Service Phone Number: ____________________

Claims: Insurance Provider

(If no address provide claim phone number) ____________________

Address ____________________

City, State, Zip ____________________

This reflects my understanding that it is my responsibility to obtain and maintain health insurance while I am enrolled as a student at The Christ College of Nursing and Health Sciences, in accordance with the policies and practices outlined in the Christ College of Nursing & Health Sciences College Catalog, and that the information provided above is true and accurate to the best of my knowledge and belief.

Type name to confirm acknowledgement: