SOUTHERN ILLINOIS UNIVERSITY EDWARDSVILLE
SCHOOL OF NURSING

Health Insurance Validation

☐ **Graduate** ☐ **ABS** ☐ **Traditional** ☐ **RN-BS** ☐ **School Nurse**

My health insurance coverage for ***2011 – 2012 Academic Year*** is as follows:

STUDENT'S NAME_____

STUDENT ID NUMBER_____

HEALTH INSURANCE PROVIDER_____

POLICY/ID NUMBER_____

I verify that I am covered for the current semester under the above named health insurance policy. If my health insurance coverage would change during the current semester, I will notify the School of Nursing within one (1) week of the effective date of change of coverage.

Please attach copy of current insurance card.

SIGNATURE:_____

Emergency Contact Information

Contact Person's Name_____ Relationship_____

Address_____

City, State, Zip_____

Phone_____

Date: _____

*To be retained as permanent record in student health file. Goldenrod