FIU | Herbert Wertheim College of Medicine
FLORIDA INTERNATIONAL UNIVERSITY

Health Insurance Verification Form

PART A: Student Information

Name: _____ Sex: ☐ Male ☐ Female

Date of Birth _____/_____/_____
(Month) (Day) (Year)

- Have you enrolled in the FIU Student Health insurance plan? ☐ Yes ☐ No
  If YES, proceed to Part C below. If NO, please complete Parts B & C below.

PART B: Insurance Policy Information

Name of Insurance Company: _____

Policy #: _____ Group #: _____
Type of Insurance: ☐ PPO ☐ HMO ☐ Indemnity ☐ Other ☐ Unknown
Effective Date: _____ End Date (*unless renewed)*: _____
Name of Insured or policy holder: _____ Relationship to student: _____

Part C: Verification and Statement of Financial Responsibility

- Verification of your insurance coverage may be made by one of the following ways:

☐ Photocopy of valid insurance card (Upload/scan the front and back of this document to your American DataBank Complio account AND this form).

☐ Photocopy of your insurance policy summary sheet that demonstrates uninterrupted coverage for an entire year (Upload this proof to your American DataBank account with this form).

- I, _____, hereby certify that I am personally covered by health insurance or an equivalent health care plan as required by Florida International University (FIU) Herbert Wertheim College of Medicine (HWCOM). If the HWCOM determines that the above coverage does not comply with the basic health insurance requirement, I understand and agree that the HWCOM may charge my University account for health insurance coverage, and I agree to pay all such charges in accordance with University policy. I understand and agree that I will be responsible for any and all charges for health care services regardless of whether or not covered by insurance or equivalent plan. I further understand and agree that the FIU HWCOM and all of its representatives will not be responsible for paying for or providing any medical/hospital care or health insurance coverage for me.

  The above information is requested for the purpose of compliance with the health insurance requirement for HWCOM students. The information will only be used by the Office of Student Affairs for the purpose of identifying and evaluating health care financial responsibility information in accordance with established requirements and will not be released to any party outside the HWCOM without my written permission, except as permitted by law.

I understand and agree that I must complete this form at the start of each academic year and **whenever my health insurance coverage changes for any reason.**

Signature:_____ Panther ID #:_____

Date:_____

Upload this form and supporting documents to your American DataBank Complio online account.