University of Iowa Student Health
INSURANCE INFORMATION

Name _____

Birth Date _____

Student ID#_____

PLEASE INCLUDE A COPY OF THE FRONT AND BACK OF YOUR INSURANCE CARD

I. Employer of Policyholder: _____

Primary Policyholder Information:

Name of Policyholder: _____
Address of Policyholder: _____
(Street) (City) (State) (Zip)
Phone of Policyholder: (_____) _____--_____
Birth Date of Policyholder: _____/_____/_____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Partner ☐ Father ☐ Mother ☐ Other_____

Primary Insurance Information:

Insurance Company: _____
Address of Insurance Co: _____
Phone Number(s): (_____) _____--_____; (_____) _____--_____
Policy Number: _____
Group Number: _____

****Do you have other health insurance?** ___Yes ___ No If yes, please complete the following information:

II. Employer of Policyholder: _____

Secondary Policyholder Information:

Name of Policyholder: _____
Address of Policyholder: _____
(Street) (City) (State) (Zip)
Phone of Policyholder: (_____) _____--_____
Birth Date of Policyholder: _____/_____/_____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Partner ☐ Father ☐ Mother ☐ Other_____

Secondary Insurance Information:

Insurance Company: _____
Address of Insurance Co: _____
Phone Number(s): (_____) _____--_____; (_____) _____--_____
Policy Number: _____
Group Number: _____

WE RECOMMEND THAT YOU HAVE YOUR INSURANCE CARD WITH YOU AT SCHOOL

Return this form to:
Mail: University of Iowa Student Health
4189 Westlawn, Iowa City, IA 52242-1100
Fax: 319-335-7247
Email: student-health@uiowa.edu

For questions visit our website at http://studenthealth.uiowa.edu/ or call 319-335-8370