

UNIVERSITY OF MIAMI
LEONARD M. MILLER
SCHOOL OF MEDICINE
FAU Regional Campus at Boca Raton
Academic Year 2009-2010

**STUDENT HEALTH INSURANCE COVERAGE
AGREEMENT**

Type of Policy: () Individual () Parents () Spouse () Group

Group or Individual POLICY NUMBER (if applicable) _____

If available: Effective Date: _____ Expiration Date: _____

PLEASE CHECK INSURANCE CARRIER and attach copy of insurance card
(if you have received it)

() **FAU Policy** - United HealthCare Insurance Company
P.O. Box 809025
Dallas, TX 75380-9025
Tel: (800) 767-0700

() **UMMSOM** - United HealthCare Insurance Company
P.O. Box 740800
Atlanta, GA 30374-0800
Tel: (800) 436-7709

OTHER

() Insurance Company: _____

Policy Number: _____

Address: _____

City, State, Zip: _____

I _____ do hereby certify that I am
(Please Print)

covered by Health Insurance and will maintain health insurance coverage
during the academic year. If I change insurance carriers or if my policy is
changed during the academic year, I will notify the Office of the Registrar in
writing.

Student's Signature: _____ Date : _____

Class of 2013

Please return this form at registration after that date please return to BC 145 Dean's Office. Please
attach a copy of your insurance card