Shimer
The Great Books College of Chicago

Deadline: □ Fall/Spring*	**Aug. 22, 2016**
□ Fall	Aug. 22, 2016
□ Spring	Jan. 4, 2017

*Both semesters can be verified in the Fall

Student Health Insurance Verification Form

Academic Year 2016-2017

Illinois law requires that all registered full-time students carry accident and health insurance while attending school. Students must provide verification of insurance.

Please complete this form and attach a copy of both the front AND back of your insurance card.

Verification of insurance must be on file with the Office of Student Life prior to the first day of classes. Failure to submit the verification form can result in a student being administratively withdrawn from classes. This requirement applies to all newly admitted students, readmitted students, and transfer students.

A NEW VERIFICATION FORM MUST BE COMPLETED AT THE START OF EACH ACADEMIC YEAR

STUDENT INFORMATION (please print)		
Last Name	First Name	M.I.
Student ID Number	Date of Birth	

MEDICAL INSURANCE INFORMATION (please print)		
Name of Medical Insurance	Billing Address	Contact Phone Number
Subscriber's Name	Subscriber's Relationship to Student	
Subscriber's ID #	Group #	Policy #
□ Copy of the front and back of medical insurance card is attached to this form.		

Special Note for Health Insurance Coverage for Illinois: **All students** need to have health insurance coverage that can be used in the Chicago area. Out of state students and in-state students should contact their health care providers to request and confirm that they will have health insurance coverage in Chicago, IL.

Certification

I hereby certify that the above policy will remain valid for the remainder of this academic year. I understand and agree that I must maintain health insurance at all times during my enrollment as a full-time student at Shimer College. I understand and agree that if my health insurance coverage is terminated, I must immediately notify the Office of Student Life and will be required to show proof of new coverage within a reasonable period of time. I understand that I may be randomly selected for a full policy review.

Signature: _____ Date: _____

Parent's Signature: _____Date:_____
(if under 18)

OFFICE USE ONLY	**Received:**
Reviewer initials/date:_____	Copy of insurance card: ___Yes ___No
Comments:_____	

Last revised: 7-28-16:SB