

**IOWA STATE UNIVERSITY THOMAS B. THIELEN STUDENT HEALTH CENTER**  
**Student Health Insurance Information**

Student's Full Name: \_\_\_\_\_

Student ID Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age \_\_\_\_\_

Eligibility Status:  Undergraduate  Graduate Assistant  Post Doctorate  Spouse  Dependent

Student Status:  Full Time  Part Time – number of credits \_\_\_\_\_

**I am NOT covered by any insurance policies.** \_\_\_\_\_

*(STOP and Sign statement - do not complete rest of form)*

Student's Signature & Date

**I have the following types of insurance:** *(check all that apply)*

**Medical Insurance;**

**Pharmacy Insurance**

If the student is covered under **more than one plan**, please **list the primary insurance** in the space provided below. **Provide any secondary insurance information** - such as, the Policyholder information for this secondary plan on the back of this form.

**Please attach a copy of all active insurance cards (front & back)**

**Medical Insurance Information:**

**(\* = Required Information)**

\*Primary Policyholder's Full Name: \_\_\_\_\_

\*Relationship to Patient: \_\_\_\_\_

\*Phone Number: \_\_\_\_\_ \*Date of Birth: \_\_\_\_\_

\*Address: \_\_\_\_\_

\*City: \_\_\_\_\_ \*State: \_\_\_\_\_ \*Zip: \_\_\_\_\_

**Complete only if information is not located on copy of insurance card:**

Insurance Company: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

**Complete only if this is a new policy:**

Does this policy replace last year's policy?  Yes  No If **yes**, end date: \_\_\_\_\_

Name of previous insurance company: \_\_\_\_\_

**On my behalf or for my underage child: I authorize the release of any medical information necessary to process claims submitted to the insurance companies I have provided to the Thielen Student Health Center. I also authorize payment of benefits to the clinic/physician or supplier of services rendered indicated on the billing document.**

\_\_\_\_\_  
Student's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Signature (if patient is under 18 years of age)

\_\_\_\_\_  
Date

For Office Use Only

SID # \_\_\_\_\_ Chart made  yes  no Year \_\_\_\_\_ Entered by \_\_\_\_\_