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

*Submit insurance three ways: 1. Scan and email to: submitinsurance@iastate.edu 2. Drop off at the Student Health Center, corner of Union drive and Sheldon Avenue 3. Mail to: Student Health, **ATT**: Insurance Information, Thielen Student Health Center, 2647 Union Drive, Ames, Iowa 50011-2029*

Patient's Full Name: ______________________________

UID#: ______________ 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: ______________________________

<u>On my behalf or for my underage child</u>: 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.

______________________________ ______________

Patient's Signature Date

______________________________ ______________

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