

The University of Texas Health Science Center at San Antonio  
**Student Health Center**  
School of Nursing, Room 1.422  
7703 Floyd Curl Drive  
San Antonio, Texas 78229-3900  
Phone: (210) 567-WELL (9355)

## UTHSCSA HEALTH INSURANCE COVERAGE INFORMATION

As permitted by Texas law, the UT Board of Regents requires you to maintain a valid major medical insurance policy while you are a registered student at The University of Texas Health Science Center at San Antonio. If you are covered by health insurance, you must submit proof of coverage to the Student Health Center **each year**. This information, and the **Student Health Insurance and Acknowledgement and Disclaimer form**, are required to register at the Health Science Center.

- This form and the Disclaimer form must be completed and turned in to the Student Health Center PRIOR to the 1st Official Class Day for your program EACH YEAR.
- This form must be completed and attached to a copy of your health insurance card, if applicable, as proof of coverage EACH YEAR.
- You must present evidence of insurance coverage (health insurance card) EACH TIME you visit the Student Health Center just as you would when visiting any other health provider.

Verification Year: From \_\_\_\_\_ To: \_\_\_\_\_  
Month/Year Month/Year

I plan to pay for all of my health care costs I may incur during my enrollment at UTHSCSA through one of the following methods:

- Please bill me for United HealthCare student insurance. I understand this fee will be included on my Tuition & Fees bill.
- Enrolled in a UTHSCSA employee insurance plan
- Coverage through military/military dependent health care benefits

Policy Holder/Relationship: \_\_\_\_\_

Health Insurance Company: \_\_\_\_\_ Policy #: \_\_\_\_\_

Date of Coverage: \_\_\_\_\_ to \_\_\_\_\_

- Coverage under my parents'/spouse's health insurance plan

Policy Holder/Relationship: \_\_\_\_\_

Health Insurance Company: \_\_\_\_\_ Policy #: \_\_\_\_\_

Date of Coverage: \_\_\_\_\_ to \_\_\_\_\_

- Enrolled in a national student association plan

TMA       ASDA       AMSA      Policy #: \_\_\_\_\_

Date of Coverage: \_\_\_\_\_ to \_\_\_\_\_

- Enrolled in other insurance plan

Health Insurance Company: \_\_\_\_\_ Policy #: \_\_\_\_\_

Date of Coverage: \_\_\_\_\_ to \_\_\_\_\_

By signing below, I verify that I understand it is my responsibility to have continuous health insurance coverage while a student at UT Health Science Center and to use my own resources to pay for my health care expenses other than those covered by the Student Health Center.

Printed Name: \_\_\_\_\_ HSC Badge#: \_\_\_\_\_

Telephone: \_\_\_\_\_ Emergency telephone: \_\_\_\_\_

School/Program: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_