



UM-Medical School Diversity and Career Development Office  
Summer Science Academy



**HEALTH INSURANCE INFORMATION SHEET**

**NOTE: EVERY PARTICIPANT MUST HAVE THIS FORM ON FILE**

Private insurance information must be provided, if applicable. If a participant does not have private health insurance, please be advised that, should a participant require medical attention, **you are responsible for paying any costs not covered by insurance.**

Participant Name \_\_\_\_\_ Participant's Soc Sec # \_\_\_\_\_

Participant's Address \_\_\_\_\_  
Street City State Zip

Participant's Phone Number(s) \_\_\_\_\_ Date of Birth \_\_\_\_\_

Insurance Company Name \_\_\_\_\_ Effective Date \_\_\_\_\_

Address of Insurance Company \_\_\_\_\_

Phone Number of Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_

Policyholder's Name \_\_\_\_\_ Policy # \_\_\_\_\_

Policyholder's Address \_\_\_\_\_  
Street City State Zip

Relationship to Participant \_\_\_\_\_

Contract # \_\_\_\_\_ Employee # \_\_\_\_\_

Name and Phone Number of Primary Care Physician:

\_\_\_\_\_

**I hereby authorize the release of any medical information which might be needed in connection with payment for medical services.**

Participant Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

**I request that payment under my medical insurance program be made directly to the provider on any bills for services rendered by that provider. I understand that I am financially responsible for fees not covered by this authorization.**

Participant Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_