OUHSC/Department of Family Medicine
College of Allied Health Student

STUDENT INFORMATION

Name: _____ Date of Birth: _____ Sex: ☐ M or ☐ F

Home Address: _____

City: _____ State: _____ Zip Code: _____

University ID#: _____ Telephone Number (____) _____ Cell (____) _____

College Attending: **Allied Health** Expected Graduation Year: _____

EMERGENCY CONTACT INFORMATION

Name: _____

Relationship _____ Phone Number (____) _____ Cell (____) _____

INSURANCE INFORMATION

COMPLETE ALL INFORMATION BELOW IN ITS ENTIRETY.

All students are required by the Board of Regents to have health insurance. Students may purchase the OUHSC student policy or a policy from an insurance company of your choice.

Name of Primary Policy Holder: _____

Relationship to Policy Holder: Spouse ☐ Dependant ☐ Self ☐

Name of Insurance Company: _____

Address of Insurance Company: _____

Group #: _____ Policy ID #: _____ Effective Date: _____

Select one of the following:

☐ **I have attached a copy of the front and back of my health insurance card**, so I will not purchase the Student insurance plan provided by the OU Health Sciences Center.

☐ I will purchase the OUHSC Student insurance plan provided by OU Health Sciences Center and upload a copy of the front and back of my health insurance card to my student account no later than one week before the first day of classes begins.