University of Hawai'i Leeward Community College
96-045 Ala Ike, Pearl City, HI 96782-3393 Phone 808-455-0515 Fax 808-455-0267

HEALTH INSURANCE INFORMATION SHEET

1) PATIENT INFORMATION

NAME: Last	First	Middle	UH ID#

DATE OF BIRTH: / / MM DD YY	SEX/GENDER:	UH EMAIL ADDRESS:

Local Address	City :	State:	Zipcode:	Phone: ( )

Permanent address:	City:	State:	Zipcode:	Phone: ( )

Occupation:	Employer:

Address:	Phone: ( )

EMERGENCY CONTACT:	Relationship:	Phone: (H) ( )	Phone: (Work) / (Cell) ( )

2) PRIMARY INSURANCE COMPANY:

Name of Insurance:	Policy or ID#:	Group #:

Subscriber:	Subscriber Date of Birth:	Plan #:	Cov. Code:

Subscriber Address:	City:	State:	Zip:

Subscriber Phone: ( )	Effective Date:	Expiration Date:

Relationship to subscriber: child (c) spouse (p) self (s) other (o)

3) SECONDARY INSURANCE COMPANY:

Name of Insurance:	Policy or ID#:	Group #:

Subscriber: :	Subscriber Date of Birth:	Plan #:	Cov. Code:

Subscriber Address:	City:	State:	Zip:	Effective Date:	Expiration Date:

Relationship to Subscriber: child (s) spouse (p) self (s) other (o)

INSURANCE CARRIER: I hereby authorize release of information necessary to file a claim with my insurance company and assign benefits otherwise payable to me, to the University of Hawai'i at Manoa, University Health Services as indicated on the claim. I understand I am financially responsible for any balance not covered by my insurance carrier.

SIGNATURE OF STUDENT (Parental signature required if under 18) Date

PERSONAL HEALTH CLEARANCE INFORMATION - I hereby authorize the release of my health clearance information to other campuses within the University of Hawai'i System to be used for enrollment and transfer purposes between UH campuses.

SIGNATURE OF STUDENT (Parental signature required if under 18) Date

Revised 5/2018