

**University of Arkansas for Medical Sciences
Academic Health Plans
2009-2010**

University of Arkansas Board of Trustees' policy (Policy 1260.1) requires that all students attending UAMS must be covered by health insurance.

Student's Name _____ College _____

Home Address _____
(Street) (City) (State) (Zip)

Student Resources Policy Period: Annual _____ Fall _____ Spring _____ Summer _____

Jr. & Sr. Medical and Sr. Pharmacy Students only: Annual _____ Semi-Annual _____

Check 1) or 2)

1) ___ I will purchase Injury and Sickness insurance coverage under the University's student insurance plan.

OR

2) ___ I certify that I am currently covered by the University's student insurance plan.

I certify that I will maintain such coverage as long as I am a student at UAMS (including all programs based at UAMS facilities apart from the main campus in Little Rock, such as the Area Health Education Centers). I understand that I may be asked at any time to provide proof of such coverage.

I understand that if it is determined at any time that I am not covered by such insurance, or if any information contained on this form is false, that I may be subject to immediate dismissal from UAMS. I further understand that if I incur any medically related charges at UAMS that are not covered by my insurance, UAMS is under no obligation to cover any portion of these charges. Finally, I understand that if at the time of graduation I owe monies to UAMS for any reason, including failure to pay health-related charges not covered by my insurance, it may result in my being unable to complete the campus clearance process, and I may not be eligible to graduate.

I understand by signing this form that:

1) I have completed the UAMS student insurance plan application process and I am covered by that plan

OR

2) I must contact the UAMS Student Activities Office (501-686-5850) to apply for coverage by the UAMS student health plan

Signature _____ Date _____
(Student Signature)