

Complete ONE (1) of the following forms if you are a full-time student.

**University of Arkansas for Medical Sciences
Student Resources Health Insurance Certification
2007-2008**

University of Arkansas Board of Trustees' policy (Policy 1260.1) requires that **all full time 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 _____

I _____ elect to purchase Injury and Sickness insurance coverage under the University's student insurance plan. I certify that I am currently covered by health insurance and that I will maintain such coverage as long as I am a full-time 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.

Signature _____ Date _____
(Student Signature)

OR

**University of Arkansas for Medical Sciences
Student Health Insurance Waiver form for 2007-2008**

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

Student's Name _____ College _____

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

Name of Insured _____ Relation to student _____

Name of Insurance Company or Group _____

I _____ elect not to purchase student health insurance offered by the University of Arkansas for Medical Sciences. I certify that I am covered by health insurance, as described above, and that I will maintain such coverage as long as I am a full-time 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.

Signature _____ Date _____
(Student Signature)