Insurance Demographic Information - Boston College Account # 20315635

****Please Note: It is your responsibility to provide accurate and thorough information regarding your insurance. Failure to do so may result in a bill from Lab Corp being sent to the Policy Holder.**

*****Please Note: There may still be a co-pay/deductible requirement that must be paid depending on individual insurance plans or charges for out of network services, which will be your responsibility to pay.**

University Health Services is not responsible for any charges incurred for lab work.

By completing this form you acknowledge the above information.

PLEASE BE SURE TO COPY ALL INSURANCE ACCURATELY FROM YOUR INSURANCE CARD TO AVOID UNNECESSARY BILLING ISSUES.

Signature:____

Print Name: ____ **Eagle ID #:** __________________

LAST NAME **FIRST NAME**

Your Home Address:

Street Address: ____

City/Town _________________________________ **State:** _______ **Zip Code:** __________

Your Cell Phone Number: (______) _______-_________

E-mail (International Students): ____

Name of Policy Holder:____

Relationship to you (student): Please Check

Self: _____ **Parent/Guardian** _______ **Spouse** _________ **Other (explain)** __________

Address of Policy Holder:

Street Address: ____

City/Town ______________________________ **State:** _______ **Zip Code:** __________

Name of Insurance Company: ____

Insurance Policy #: ____

****SR ID # (United Healthcare through B.C.):**____

Group # (if one is listed on the insurance card) ________________________ ________________

Insurance Company Address: (usually found on the back of the card)

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Insurance Company Phone (if available on card): (_____) _____ - _______