## 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.

LAST NAME  FIRST NAME    Your Home Address:	Print Name:	Eagle ID #: _	
Street Address:	LAST NAME	FIRST NAME	
City/TownState:Zip Code: _    Your Cell Phone Number: ()    E-mail (International Students):    Name of Policy Holder:	Your Home Address:		
Your Cell Phone Number: ()	Street Address:		
E-mail (International Students):	City/Town	State: Zip C	ode:
Name of Policy Holder:    Relationship to you (student): Please Check    Self:  Parent/Guardian    Address of Policy Holder:    Street Address:	Your Cell Phone Number: ()		
Relationship to you (student): Please Check    Self:  Parent/Guardian  Spouse  Other (explain)    Address of Policy Holder:  Street Address:	E-mail (International Students):		
Self:  Parent/Guardian  Spouse  Other (explain)    Address of Policy Holder:  Street Address:	Name of Policy Holder:		
Address of Policy Holder:    Street Address:    City/Town    Name of Insurance Company:    Insurance Policy #:    **SR ID # (United Healthcare through B.C.):    Group # (if one is listed on the insurance card)	Relationship to you (student): Please Ch	eck	
Street Address:	Self: Parent/Guardian	Spouse Other (ex	kplain) <sub>.</sub>
City/Town State: Zip Code:	Address of Policy Holder:		
Name of Insurance Company:	Street Address:		
Insurance Policy #: **SR ID # (United Healthcare through B.C.): Group # (if one is listed on the insurance card)	City/Town	State: Zip (	Code: _
**SR ID # (United Healthcare through B.C.): Group # (if one is listed on the insurance card)	Name of Insurance Company:		
Group # (if one is listed on the insurance card)	Insurance Policy #:		
	**SR ID # (United Healthcare through B.C	.):	
Insurance Company Address: (usually found on the back of the card)	Group # (if one is listed on the insurance	card)	
	Insurance Company Address: (usually fou	nd on the back of the card)	