



**University of Nebraska – Lincoln  
University Health Center**

**Healthy Option Student Insurance Information**

*Please print clearly and complete all information.*

Last Name		First Name	Middle Initial
Local Address		City/State/Zip	
Date of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	UNL ID # / Social Security #	
Telephone (Local/Cell)	University of Nebraska Student <input type="checkbox"/> UNL <input type="checkbox"/> UNK <input type="checkbox"/> UNO <input type="checkbox"/> UNMC <input type="checkbox"/> Other _____		

EMERGENCY CONTACT		
Name	Telephone (     )     -	
Street Address	City/State/Zip	Country
Relationship		

**INSURANCE COMPANY: Aetna Student Health**

ANNUAL AUTHORIZATION
<p>I consent to the use or disclosure of my protected health information by the University Health Center (UHC) for the purpose of analyzing, diagnosing, and providing treatment to me, obtaining payment for health care services rendered or to be rendered, or to conduct health care operations. A copy of this consent is as valid as the original.</p> <p>I authorize my insurance benefits to be paid directly to the University Health Center (UHC). I assume full responsibility for and agree to pay for all services rendered or to be rendered. I understand I have a right to receive a copy of this consent upon request, and to revoke this consent in writing at any time except to the extent that UHC has taken action in reliance on this consent.</p> <p>This authorization is valid one year from the date signed or through the term of coverage of the policy, and during the required period to process the claims.</p> <p>Patient/Parent/Guardian Signature _____ Date _____</p>