West Valley/Mission Community College District

Verification of other Health Insurance

Student's Name:____

Social Security Number:____

1. Are you covered under a health insurance or HMO plan
through your employer? Yes _________ No __________

Name of insurance company or HMO ____________________________________

Policy or Plan number ____

2. Are you covered under a health insurance or HMO plan as a
dependent, either through your parents or spouses employment?
Yes __________ No __________

If yes, name and relationship of policyholder ____________________________

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3. Are you covered by any other type of health plan? Yes______ No _____

If yes, name of policyholder ____

Name of insurance company or HMO ____________________________________

Policy or Plan number ____

I certify that the above is true and complete to the best of my knowledge.

______________________________________ ______________________________________

Signature **Date**