

# FSU Nurse Anesthesia Program – Panama City

## Domestic Health Insurance WAIVER

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**Veterans:** Your VA coverage will be sufficient to meet the health insurance requirements for NAP. You **do** need to complete the waiver. Enter the name, address and telephone number of the VA clinic where you are registered for services. Your policy number is your military ID number.

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_

Name of insurance company\*: \_\_\_\_\_

US claims mailing address: \_\_\_\_\_

Customer Service telephone number of insurance company: \_\_\_\_\_

Policy number/Member ID/Subscriber ID on insurance card: \_\_\_\_\_

Policy group number: \_\_\_\_\_ (optional)

Effective date of coverage: \_\_\_\_\_ (must be on or before the first day of the term as outlined in requirements: **August 15**, January 1, and May 10)

Termination date of your coverage: \_\_\_\_\_ (if VA is insurer, do not enter a date)

Please answer the following questions:

1. Is your plan compliant with the Affordable Care Act? **Y or N**
2. Is your coverage for the entire academic year, including holidays and the summer break? **Y or N**
3. Does your plan provide in-patient and out-patient mental health coverage? **Y or N**
4. Does your plan provide for needle-stick and face splash coverage? **Y or N**
5. Does your plan have a provider network in the Bay County area that provides not only emergency care but also provides routine, urgent, specialty, diagnostic, and hospital care? **Y or N**
6. Does your plan have prescription coverage? **Y or N**

Student's Printed Name: \_\_\_\_\_

Student's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

***\*Please provide a copy of your insurance card for verification.***