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Please verify that the insurance policy you have issued to the above named person meets or exceeds the following requirements:

(1) Medical benefits of Me ` qsric itn l' Į ᴀ f

Date:
Address: **City:**
State: **Country:** **ZIP:**
Phone: **Fax:** **E-mail:**

Please mail or fax this form to your client or directly to the following:

,QWHUQDWLRQDO &HQWHU
University of North Florida
1 UNF Drive
Jacksonville, FL 32224

For information **E-MAIL:** LQVWFHQWHU **@unf.edu**
TEL: 904-620-
FAX: 904-620-