Florida A&M University
Graduate Studies and Research
Certification of Eligibility for

Graduate Insurance Form

This form is used to determine graduate assistant and University-approved fellow eligibility to receive a full or partial supplement of insurance costs by the University. Graduate students employed as Other Personnel Service (OPS) workers are not eligible for this coverage. To receive continued coverage, students must complete this form at the beginning of the fall semester (up to two weeks after class begins) and at the beginning of the spring semester (up to two weeks after class begins). For more information regarding the University-sponsored health insurance plan, please go to: **http://www.famu.edu/index.cfm?graduatestudies&Insurance**. Please note that completing this form does not guarantee coverage. Also, this form must be typed and should be submitted to the Graduate School at: Gradstudies@famu.edu

Today's Date:_____ Semester(s) of Employment: ☐Fall ☐Spring ☐Summer

Name of Graduate Assistant: (*Last, First, MI*)
FAMU Student I.D. #: (***SSN# will <u>not</u> be accepted***) Date of Birth: mm/dd/yyyy
Street Address: City: State: Zip Code:
FAMU Email: Other Email:
Telephone Numbers Cell: Permanent: Other:
May we contact you by text message, if necessary: [select]
U.S. Citizen: [select] Gender: [select]
Graduate Discipline: Degree Seeking: [select]
Expected Date of Graduation: Term: [select] Year:
Department of Employment:
Supervisor: Campus Phone:
Hours contracted for per week: Current Insurance Status: [select]

I certify that all information that I have provided above is accurate and true. I understand that false information will result in the cancellation of the policy.

_____ _____
Student Signature Date

_____ _____
Supervisor Signature Date

For Office Use Only

☐Eligible ☐Not Eligible ☐Paperwork Submitted Contract Period:_____

☐E&G ☐C&G (Grant Title_____ PI_____)

Eligibility determined by:_____Signature:_____ Date: _____

☐GA notified Notified by:_____ via: ☐e-mail ☐Phone Date: _____

Submitted to Insurer by:_____ Signature:_____ Date: _____

[T *Dean's Signature*_____ Date:_____