

**Indiana University**  
**Employees & Graduate Appointees**  
**Covered by an IU Sponsored Medical Plan**

Employee ID#/University ID#: \_\_\_\_\_

Name: (please print) \_\_\_\_\_

Home Address: \_\_\_\_\_

City, State & Zip: \_\_\_\_\_

Name of Insured: (if different) \_\_\_\_\_

Insurance ID#/Member ID#: \_\_\_\_\_

Campus or Cell Phone Number \_\_\_\_\_

I hereby authorize Indiana University Health Center to furnish any and all information pertaining to the flu shot service provided to me to my insurance company or Human Resources to enable my charge to be processed for payment. I understand that I will be responsible for payment of the flu shot if it is denied by my insurance company or Human Resources.

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_