Indiana University
Employees, Graduate Appointees and Fellowship Recipients Covered by an IU Sponsored Medical Plan

Employee/University ID #: _____

Name: (please print) _____

Home Address: _____

City, State & Zip: _____

Name of Insured: (if different) _____

Insurance Identification#: _____

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 University Human Resource Services 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 University Human Resources Services.

Signature: _____ **Date:** _____/_____/_____