Indiana University Employees and Student Academic Appointees Covered by an IU Sponsored Medical Plan

Employee ID #: ______________________________

Name: (please print) ______________________________

Home Address: ______________________________

City, State & Zip: ______________________________

Name of Insured: (if different)______________________________

Insurance ID#: ______________________________

Campus 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 Anthem Blue Cross & Blue Shield 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 Anthem Blue Cross & Blue Shield or University Human Resources Services.

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