DIOCESE of SAN BERNARDINO

Medical Insurance Information Form

I have no medical insurance. ☐

I am insured under a diocesan/seminary assigned plan. ☐

I am covered under my parents medical insurance policy. ☐

NAME OF PLAN:_____

****Return a copy of medical insurance card**

I am responsible for my own medical insurance coverage. ☐

NAME OF PLAN:_____

****Return a copy of medical insurance card**

ALL SEMINARIANS IN THE DIOCESE OF SAN BERNARDINO ARE REQUIRED TO HAVE MEDICAL INSURANCE COVERAGE

I swear under penalty of perjury the above to be true and correct.

Name:_____

Signature:_____ Date:_____

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