HEALTH INSURANCE ACKNOWLEDGEMENT

By signing below, I acknowledge and understand that I am required to maintain health insurance coverage while enrolled in the Doctor of Pharmacy program at the Texas A&M Rangel College of Pharmacy and will ensure there is no lapse in coverage. I shall provide evidence of coverage by uploading a copy of my insurance card to the college's designated portal each year I am enrolled in the program and anytime my coverage changes. I also acknowledge and understand that failing to maintain coverage, or to provide evidence of coverage, may result in my withdrawal from the program.

Name (Print): ____

Signature: ____ Date: ____________________