# Health Insurance Attestation for Non-Employees at the Massachusetts General Hospital

*this form is due 10-days prior to the observership start date*

**Name of Policy Holder:** _____
*First Name* *Middle Name* *Last/Sur Name*

**Name of Insured:**
(if different from policy holder) _____
*First Name* *Middle Name* *Last/Sur Name*

**Insurance Provider:** _____
*Name of Company*

_____
*Street Address 1*

_____
*Street Address 2*

_____ _____ _____ _____
*City* *State/Province* *Postal Code* *Country*

_____
*Telephone (please include country / city code)*

**Policy #:** _____

## Attestation

I attest that I have read the MGH Non-Employee Health Insurance Requirements. I understand that:

- if I am injured at MGH, I am not covered under the MGH Worker's Compensation Policy
- if I am injured at MGH, the incident should be reported to my sponsoring supervisor and that I should seek medical care by going to the medical walk in clinic at MGH, an Emergency Department (MGH or other nearby Emergency facility), or make arrangements to see my own physician for medical evaluation and treatment, as appropriate
- I will be financially responsible for medical services rendered

_____ _____ _____
*Signature* *Print Name* *Date*