# Proof of Medical Insurance

Date: _____

To Whom It May Concern,

This document certifies that the individual listed below has active medical insurance coverage.

| | |
|---|---|
| Full Name: | |
| Date of Birth: | |
| Insurance Provider: | |
| Policy Number: | |
| Coverage Period: | From _____ to _____ |

Should you require further verification, please contact the insurance provider cited above.

Authorized Signature: _____

Contact Number: _____