PARENT INFORMATION/INSURANCE FORM

FAILURE TO COMPLETE ALL BLANKS WILL RESULT IN CLAIMS PROCESSING DELAYS.

Please submit 2 copies of front and back of insurance card(s).

Name of Athlete:_____ Sport:_____
College Address:_____ Local Phone:_____
City: _____ State:_____ Zip Code: _____

Father/Guardian:_____ Birth date: _____
Address:_____
Employer: _____
Phone:_____ Social Security No. _____
Insurance Company:_____
Claims Address: _____
Phone No:_____ Policy No._____ Group No. _____
Is this plan an: HMO _____ EPO _____ PPO _____ Other _____
Is the athlete covered by this plan? YES _____ NO _____
Is this plan: Primary _____ Secondary _____

Mother/Guardian:_____ Birth date: _____
Address: _____
Employer: _____
Phone: _____ Social Security No. _____
Insurance Company:_____
Claims Address: _____
Phone No:_____ Policy No._____ Group No. _____
Is this plan an: HMO _____ EPO _____ PPO _____ Other _____
Is the athlete covered by this plan? YES _____ NO _____
Is this plan: Primary _____ Secondary _____

Athlete's Personal Insurance Information (If not covered by Parent/Guardian Insurance)
Insurance Company:_____
Claims Address: _____
Phone No:_____ Policy No._____ Group No. _____
Is this plan an: HMO _____ EPO _____ PPO _____ Other _____

I hereby authorize (School Name Here) _____ to inspect or secure copies of case history records, laboratory reports, diagnosis, x-ray, and other data covering this and/or previous confinements and/or disabilities. A photo copy of this authorization shall be deemed as effective and valid as the original. Drafts for benefits will automatically be sent to the hospital, doctor, or other supplier of medical services. I further certify that I have read and understood the attached insurance information letter.

Parent's/ Guardian's Signature:_____
Student's Signature:_____
Date:_____

UNTIL THIS FORM IS **COMPLETED** AND **RETURNED** TO THE HEAD ATHLETIC TRAINER, THE ATHLETE**WILL NOT** PARTICIPATE IN PRACTICE.