

PARENT/ATHLETE INSURANCE INFORMATION FORM

Parent/Athlete failure to complete filling in all blanks will result in claims processing delays. Please indicate if the information requested is not applicable with "N/A." If there is a change in insurance status during the academic year, please inform the Head Athletic Trainer immediately.

ATHLETE:

Name: _____ Birth date: _____

NOTE: If the athlete has individual insurance information due to independent status, please indicate the insurance information below as "self." If the athlete is covered by primary and secondary insurance, please fill out both below.

Circle primary insurance subscriber: SELF FATHER MOTHER OTHER _____

Name: _____ Social Security #: _____

Home Address: _____

Home Phone: _____

Employer: _____ Work Phone: _____

Work Address: _____

Insurance Company/Plan: _____

ID/Policy #: _____ Group #: _____

Annual deductible (please circle): \$ 0 100 250 500 750 1,000 Other _____

Insurance Claims Address: _____

Member Service / Claims Phone: _____

IS THIS PLAN AN: HMO PPO OTHER (please specify) _____

IS PREAUTHORIZATION REQUIRED TO OBTAIN TREATMENT? YES NO

IS A SECOND OPINION REQUIRED BEFORE SURGERY? YES NO

Circle secondary insurance subscriber: SELF FATHER MOTHER OTHER _____

Name: _____ Social Security #: _____

Home Address: _____

Home Phone: _____

Employer: _____ Work Phone: _____

Work Address: _____

Insurance Company/Plan: _____

ID/Policy #: _____ Group #: _____

Annual deductible (please circle): \$ 0 100 250 500 750 1,000 Other _____

Insurance Claims Address: _____

Member Service / Claims Phone: _____

IS THIS PLAN AN: HMO PPO OTHER (please specify) _____

IS PREAUTHORIZATION REQUIRED TO OBTAIN TREATMENT? YES NO

IS A SECOND OPINION REQUIRED BEFORE SURGERY? YES NO

I/we hereby authorize Midway College to inspect or secure copies of case history records, laboratory results, diagnosis, x-rays and any other data covering this and/or previous confinements and/or disabilities. A photostatic copy of this authorization shall be deemed as effective and valid as the original.

I/we authorize Midway College to pay the medical vendors for any bills incurred from athletic-related accidents that are covered under the secondary payment plan offered by Midway College.

Parent's Signature (if applicable): _____

Athlete's Signature: _____