

WESTMINSTER



**ATHLETIC
TRAINING**

Family Insurance Information Form

Note: Complete all blanks on this form. Failure to complete all blanks will result in claims processing delays.

If information is not applicable, indicate the reason it is not (e.g., deceased, divorced, unknown).

Name of Athlete	_____	Preferred Name	_____
	(First) (Middle) (Last)	Sport(s)	_____
SSN or Passport No.	_____	Date of Birth	_____
Home Address	_____	Home Phone	() _____
City	_____	State	_____
		Zip	_____
Local Address	_____	Local Phone	() _____

Father/ Guardian Information	Mother/Guardian Information
Name _____	Name _____
Date of Birth _____	Date of Birth _____
SSN _____	SSN _____
Address _____	Address _____
Telephone () _____	Telephone () _____
Employer _____	Employer _____

Student-Athlete Primary Health Insurance	Student-Athlete Secondary Health Insurance
Health Insurance _____	Health Insurance _____
Carrier _____	Carrier _____
Address _____	Address _____
Telephone () _____	Telephone () _____
Name of Policy Holder _____	Name of Policy Holder _____
Member ID/ Policy # _____	Member ID/ Policy # _____
Group # _____	Group # _____
Is this plan an HMO or PPO (circle if yes)? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is this plan an HMO or PPO (circle if yes)? <input type="checkbox"/> Yes <input type="checkbox"/> No
Is pre-authorization required to obtain treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is pre-authorization required to obtain treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No
Is a second opinion required before surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is a second opinion required before surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No

I/We authorize Westminster College and First Agency of Kalamazoo, MI to inspect or secure copies of case history records, laboratory reports, diagnosis, x-rays, and any other data covering this and/or previous confinements and/or disabilities.

A copy of this authorization shall be deemed as effective and valid as the original.

I/We agree that for expenses not covered by the Westminster College Secondary insurance policy, I/we will assume responsibility for.

Student-Athlete Signature	_____	Date	_____
Parent/Guardian Signature	_____	Date	_____

*Parent/Guardian must sign if student-athlete is covered by his/her health insurance policy.