**MEDICAL INSURANCE INFORMATION**

Athlete's Name: ______________________________________________ Date of Birth: ____________
Last First Middle
Social Security #: ____________________ Home Phone: ________________ Cell Phone: ________________
Home Address: ________________________________________________________________
School Address: ________________________________________________________________
Street/PO Box City State Zip

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Policy Holder's Name: ______________________
Social Security #: ______________________
Date of Birth: ______________________ Phone: ________________
Address: ________________________________________________________________
Street/PO Box City State Zip
Employer: ________________________________________ Phone: ________________
Address: ________________________________________________________________
Insurance Company: ________________________________ Phone: ________________
Address: ________________________________________________________________
Street/PO Box City State Zip
Group #: ______________________
ID #: ______________________
Policy#: ______________________

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Secondary Insurance Coverage (Parent/Guardian): ____________________________
Social Security #: ______________________
Date of Birth: ______________________ Phone: ________________
Address: ________________________________________________________________
Street/PO Box City State Zip
Employer: ________________________________________ Phone: ________________
Address: ________________________________________________________________
Insurance Company: ________________________________ Phone: ________________
Address: ________________________________________________________________
Street/PO Box City State Zip

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**Does the above mentioned primary policy cover the following?**

| | | | | | |
|---|---|---|---|---|---|
| Prescription | Yes ___ | No ___ | Does this policy require pre-authorization for medical care? | Yes ___ | No ___ |
| Dental | Yes ___ | No ___ | Does this policy require pre-authorization for surgery? | Yes ___ | No ___ |
| Optical | Yes ___ | No ___ | Does this policy have a designated primary care physician? | Yes ___ | No ___ |

Physician Name: ________________________________________ Phone: ________________
Address: ________________________________________________________________
Street/PO Box City State Zip

**I have read the athletic injury medical insurance policy information and understand the statements contained therein. In the event the above student-athlete sustains an athletic injury or illness, the Southwestern athletic training/sports medicine department is hereby authorized to file a claim on my behalf under the above medical insurance policy.**

**Signature of Student-Athlete**: ________________________________________ Date: ____________

**This must be completely filled out with a COPY OF YOUR INSURNACE CARD ATTACHED.**