LINDSEY WILSON COLLEGE
PRIMARY ATHLETIC INSURANCE INFORMATION

TO BE COMPLETED BY A PARENT/GUARDIAN. PLEASE PRINT OR TYPE. COMPLETE ALL BLANKS. FAILURE TO COMPLETE ALL BLANKS WILL RESULT IN CLAIMS PROCESSING DELAYS. IF INFORMATION IS NOT APPLICABLE, PLASE INDICATE THIS OR THE FOLLOWING (i.e. divorce, deceased, unknown).

Athlete's Name:____________________________________ Sport(s):__________________

SSN or Passport #:______________________ Sex:______ Date of Birth:_____________

Academic Year:__________________ Athletic Competition Year:_____________________

Home Address:____

City:______________________ State:_______________ Zip Code:________________

Home Phone #:__________________________ Cell Phone #:________________________

Primary Care Physician Name:___________________________ Phone #:_________________

Please include a photocopy of the front and back of the Primary Insurance Card.

Father/Guardian's coverage for athlete: PRIMARY or SECONDARY?___________
(Or student's own primary insurance information)

Father/Guardian's Name:____

SSN:____________________ Date of Birth: ________________________

Home Address:____

City:______________________ State:________________ Zip Code:________________

Home Phone #:__________________________ Cell Phone #:__________________________

Employer's Name:____

Employer's Address:____

City:______________________ State:_________________ Zip Code:________________

Work Phone #:____________________________

Medical Insurance Company Name:____

Mailing Address for Claims:____

City:_____________________________ State:________________ Zip Code:_________

Policy/ ID #:___________________________ Group #:______________________________

Does your primary insurance require: Second opinion for surgery? YES or NO

Pre-authorization for services? YES or NO

Pre-authorization for non-emergency surgery? YES or NO

Is this an HMO, PPO, or Standard Health Plan?____

Please indicate any special instructions, restrictions, etc. for you insurance plan.

Please include a photocopy of the front and back of the Primary Insurance Card.

Mother/Guardian's coverage for athlete: PRIMARY or SECONDARY?___________

Mother/Guardian's Name:____

SSN:____________________ Date of Birth: __________________________

Home Address:____

City:______________________ State:_______________ Zip Code:_______________

Home Phone #:__________________________ Cell Phone #:__________________________

Employer's Name:____

Employer's Address:____

City:______________________ State:________________ Zip Code:_______________

Work Phone #:____________________________

Medical Insurance Company Name:_____________________________________

Mailing Address for Claims:____

City:____________________________ State:_______________ Zip Code:_________

Policy/ ID #:__________________________ Group #:____________________________

Does your primary insurance require: Second opinion for surgery? YES or NO

Pre-authorization for services? YES or NO

Pre-authorization for non-emergency surgery? YES or NO

Is this an HMO, PPO, or Standard Health Plan?____

Please indicate any special instructions, restrictions, etc. for your insurance plan.

I hereby authorize Lindsey Wilson College and their insurance carrier to inspect or secure copies of case history records, laboratory reports, diagnoses, x-rays, and any other data covering this and/or previous confinements and/or disabilities. A photocopy of this authorization shall be deemed as effective and valid as the original.

We authorize that Lindsey Wilson College or their insurance carrier may pay the medical vendors directly for any bills incurred from accidents that are covered under the coverage purchased by Lindsey Wilson College.

Parent/Guardian Signature:______________________________________ **Date:**_________

Student's Signature:____ **Date:**_________

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