

PARENTS/GUARDIANS – PLEASE COMPLETE THIS FORM AND RETURN IT, ALONG WITH A COPY OF THE FRONT & BACK OF YOUR INSURANCE CARD TO:

Indiana Wesleyan University
ATTN: Head Athletic Trainer
4201 South Washington Street
Marion, IN 46953-4974

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

Name: First: _____ Init: _____ Last: _____ Sport: _____
Social Security Number: _____ Date of Birth: _____
IWU Address: _____ Campus Phone: _____
Cell phone: _____ Home phone: _____
Home Address: Street: _____
City: _____ State: _____ Zip: _____

Primary Insurance: Please provide the following information regarding your primary insurance.

Name of person through whom you are insured: _____
The above person's relationship to you: _____ The above person's date of birth _____
The above person's Social Security Number: _____ (Only needed for claims to be properly processed)
Insured's Address: Street: _____ Phone: _____
City: _____ State: _____ Zip: _____

Name of Employer: _____

Employer's Address: Street: _____ Phone: _____
City: _____ State: _____ Zip: _____

Medical Insurance Company: _____

Insurance Co. Address: Street: _____ Phone: _____
City: _____ State: _____ Zip: _____

Insurance Policy Number: _____

Is the company or plan listed above considered a Health Maintenance Organization (HMO) or a Preferred Provider Organization (PPO)? Yes _____ No _____ If yes, please circle the appropriate type of plan above.

Does your insurance or plan require a second opinion before surgery? Yes _____ No _____

I hereby certify that I have completed this form to the best of my knowledge, and that the information is complete and correct. I also hereby authorized the Indiana Wesleyan University Athletic Training Staff to provide medical care to the above listed IWU athlete, and to use the information provided for insurance billing purposes as necessary

Student Signature: _____ Date _____

Parent's Signature (only needed if athlete is under 18): _____