

OTHER INSURANCE QUESTIONNAIRE

(THIS FORM SHOULD BE COMPLETED BY PARENTS PRIOR TO AN ATHLETE'S PARTICIPATION IN SPORTS AND KEPT ON FILE IN THE ATHLETIC DEPARTMENT IN THE EVENT OF A CLAIM)

Name of Student _____ Student # _____

FATHER

MOTHER

Name _____

Soc Sec # _____

Employed _____ Yes _____ No

_____ Yes _____ No

Employer _____

Address _____

City _____ State/Zip _____

City _____ State/Zip _____

Phone _____

Phone _____

Contact Person _____

Do you have Group Medical insurance coverage through your employment?

_____ Yes _____ No

_____ Yes _____ No

Ins. Co. _____

Address _____

City _____ State/Zip _____

City _____ State/Zip _____

Policy # _____

Type of Plan: _____ Health Maintenance Organization (HMO)

_____ Preferred Provider Organization (PMO)

_____ Standard Medical & Hospitalization Coverage

_____ Other (Describe)

If you have medical coverage, and your son/daughter is not covered or is partially covered due to policy limitations, please explain. _____

If your son/daughter has medical insurance coverage as an eligible dependent from your previous Marriage, as mandated in a divorce decree, please give details for filing a claim.

I/WE AGREE THAT ALL INFORMATION PROVIDED IN THIS DOCUMENT IS ACCURATE AND COMPLETE TO THE BEST OF MY/OUR KNOWLEDGE. I/WE UNDERSTAND THAT ANY INCORRECT OR UNDISCLOSED INFORMATION CAN RESULT IN DUPLICATE PAYMENTS CREATING A SUBSTANTIAL OVERPAYMENT. THE RESPONSIBILITY OF SUCH OVERPAYMENT WILL BE THE OBLIGATION OF THE UNDERSIGNED TO REIMBURSE IN FULL, UPON REQUEST, ALL AMOUNTS DEEMED REFUNDABLE.

PARENT/GUARDIAN/FATHER _____ DATE _____

PARENT/GUARDIAN/MOTHER _____ DATE _____