

Secondary Health Insurance Policy Holder Information

Policy Holder _____ DOB: _____

Social Security Number _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Email Address _____

Insurance Company _____ Phone Number _____

Group Number _____ Policy Number _____

PCP or Family Physician _____ Phone Number _____

Does your policy require: a second opinion for surgery? _____ Yes _____ No

Pre-Authorization for service? _____ Yes _____ No

Pre-Authorization Phone number _____

Please check if it is a _____ HMO _____ PPO Is a co-pay required? _____

Please attach a copy of the front and back of your insurance card.

Affidavit of No Insurance

I, the undersigned, state that: I have no insurance or any type of accident or health plan under which _____ is covered. I agree that, should it be determined at a later date that I have collectable coverage, I will reimburse Hillsdale College any collectable amount.

Signature of Parent or Guardian _____ Date _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I do here by authorize any insurance company, hospital, physician, Hillsdale College Athletic Medicine or any other person who has attended or examined the claimant to disclose, when requested to do so, any and all information with respect to any injury, policy coverage, medical history, consultation, prescription or treatment and copies of all hospital or medical records. A photo static copy of this authorization shall be considered as valid as the original. I understand that this authorization will not expire until I revoke this by notifying the Hillsdale College Department of Athletic Medicine in writing.

Signature of Parent/Guardian _____ Date _____

Signature of Student-Athlete _____ Date _____

Please include a copy of the Student-athlete's driver's license.

I hereby certify that the answers provided on this form are true and complete, to the best of my knowledge. I affirm that I have received the letter stating Hillsdale College Athletic Insurance Policies and Procedures and acknowledge I understand my responsibilities with regards to the processing of medical claims by the Hillsdale College athletic accident insurance.

Signature of Parent/Guardian _____ Date _____

Signature of Student-Athlete _____ Date _____