

VERIFICATION OF CURRENT MEDICAL COVERAGE

(Please print or type all answers.)

Student Name _____ Athletic Sport _____
SSN# _____ Date of Birth _____

Father's Name _____ Home Phone(_____) _____
SSN# _____ Work Phone(_____) _____
Home Street Address _____ City _____ St. _____ Zip Code _____
Date of Birth _____ Employer's Name _____

Mother's Name _____ Home Phone(_____) _____
SSN# _____ Work Phone(_____) _____
Home Street Address _____ City _____ St. _____ Zip Code _____
Date of Birth _____ Employer's Name _____

****Important:** A COPY OF FRONT AND BACK SIDES OF ALL INSURANCE CARDS (primary and secondary) MUST BE ATTACHED TO THIS FORM.**

Is this student covered by health insurance? YES NO
Who carries the primary insurance for this student? MOTHER FATHER
Primary Insurance Company Name _____
Insurance Company Street Address _____
City _____ State _____ Zip Code _____
Insurance Company Phone Number(_____) _____
Certificate Number _____ Group or Plan Number _____
Is there any pre-certification required? YES NO
Primary Physician Required? YES NO

Name of Primary Physician _____
Street Address _____ City _____ St. _____ Zip Code _____
Phone Number of PCP (_____) _____

Is this student covered under a secondary policy? YES NO
Who carries the secondary policy? MOTHER FATHER
Secondary Insurance Company Name _____
Insurance Company Street Address _____
City _____ State _____ Zip Code _____
Insurance Company Phone Number(_____) _____
Certificate Number _____ Group or Plan Number _____
Is there any pre-certification required? YES NO

NOTE: By signing this form you are authorizing Saint Mary College's Athletic Department to file any medical claims to your insurance company or to obtain any medical information including bills and diagnosis of the injury from the provider(s) in order to process your claim correctly. Saint Mary College will cover only services ordered or authorized by Saint Mary College's Athletic Department after denial from your insurance company.

STUDENT SIGNATURE DATE PARENT SIGNATURE DATE



Student-Athlete Contact Information Form

Name: _____ Year: _____ Sport: _____ ID#: _____

Present Address: _____ Email: _____

(Local) _____ Phone #: _____

_____ Cell Phone: _____

Permanent Address: _____

Emergency Contact: _____ Relationship: _____

Address: _____ Phone #: _____

_____ Work #: _____

Secondary Contact: _____ Relationship: _____

Address: _____ Phone #: _____

_____ Work #: _____