

**ELMIRA COLLEGE
DEPARTMENT OF ATHLETICS
INSURANCE FORM**

DIRECTIONS: Please, completely fill out the information below and send it to: Department of Athletics, c/o Sports Medicine, Elmira College, One Park Place, Elmira, NY 14901. If it is not sent out to us by August 1st, please bring this form with you to your Physical Screening. **You will not be allowed to practice till this form is on file with us.**

SECTION I PARENT OR GUARDIAN

ATHLETES NAME: (print) _____ DOB: _____

SPORT (S): _____

PARENT'S NAME: (print) _____

PARENT'S ADDRESS:

EMPLOYER INFORMATION:

STREET & NUMBER _____

COMPANY NAME _____

APT. # _____

STREET & NUMBER _____

CITY STATE ZIP _____

CITY STATE ZIP _____

HOME PHONE _____

WORK PHONE _____

SECTION II Is your daughter/son covered at this time by your insurance policy? _____ yes _____ no
If the answer is yes, please give the following information.

INSURANCE COMPANY NAME _____

FAMILY PHYSICIAN _____

NUMBER STREET PO BOX _____

NUMBER STREET PO BOX _____

CITY STATE ZIP _____

CITY STATE ZIP _____

PHONE NUMBER _____

PHONE NUMBER _____

Fill in the following numbers, which are applicable.

PLAN NAME POLICY # _____

GROUP # OTHER # _____

POLICY ISSUED TO: _____ SS#: _____

INSURED ID # _____

Check the box that best describes your insurance coverage. (TYPE)

TRADITIONAL _____ HMO _____ PPO _____ OTHER _____

Does your insurance company require you to get prior approval from your insurance company or Family Physician, before an outside Physician is consulted?

YES _____ NO _____ EXPLAIN WHO SHOULD BE CALLED: _____

Has any of the information mentioned above changed within the past year? YES _____ NO _____