

ELMIRA COLLEGE
DEPARTMENT OF ATHLETICS
INSURANCE FORM

11 - 12

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 until this form is on file with Sports Medicine. This form must be updated yearly.**

ATHLETE'S NAME (print): _____ CLASS YEAR: _____

SPORT(S): _____ DOB: _____

PARENT'S NAME (print): _____

PARENT'S ADDRESS:

_____ HOME PHONE _____
STREET & NUMBER APT. #

_____ WORK-CELL PHONE _____
CITY STATE ZIP

At this time is your daughter-son covered by your insurance policy or an independent carrier?

_____ YES _____ NO If the answer is yes, please give the following information.

Has your daughter-son insurance carrier changed within the past year? YES _____ NO _____

_____ INSURANCE COMPANY NAME

_____ FAMILY PHYSICIAN

_____ NUMBER STREET PO BOX

_____ PHONE NUMBER

_____ CITY STATE ZIP

_____ FAX NUMBER

_____ PHONE NUMBER

EMPLOYER INFORMATION OF INSURED PARENT:

_____ COMPANY NAME

_____ EMPLOYER PHONE NUMBER

Fill in the following numbers, which are applicable.

_____ PLAN NAME _____ POLICY # _____ GROUP # _____ OTHER # _____

POLICY ISSUED TO: _____ INSURED ID # _____

Check the box that best describes your insurance coverage. (Type of insurance policy)

TRADITIONAL (80/20) _____ 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: _____