**SALEM ACADEMY & COLLEGE INSURANCE INFORMATION FORM**

This form ***must be completed and on-file*** *prior to* participation in the athletics program. It is to be completed where applicable and ***signed*** even if you do not have personal insurance coverage. It is ***your responsibility*** to notify the Salem Academy & College Athletic Training Department of any changes that occur to your policy and affect the procedures in which your daughter may receive treatment. This includes loss of coverage.

**PRINT** all information and **ATTACH A PHOTOCOPY** (front and back side) of your primary insurance card

Student Athlete Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_

Soc. Sec. #: \_\_\_\_\_\_ - \_\_\_\_\_\_\_- \_\_\_\_\_\_\_ Sport(s) Playing: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **FATHER/GUARDIAN INFORMATION**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Soc. Sec. #: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_\_\_ DOB:\_\_\_\_/\_\_\_\_/\_\_\_\_\_Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City State ZipHome Phone: ( ) \_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_\_Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City State ZipInsurance Co: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Policy/ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Type of Insurance: ⁮ HMO or ⁮ PPOIs preauthorization required for medical/diagnostic services? □ YES □ NODoes your plan cover prescription medications?* YES ⁮ NO

Does your plan require a second opinion BEFORE surgery?* YES ⁮ NO

Does your plan have DENTAL coverage?* YES ⁮ NO

Is your daughter covered under this policy? YES NO | **MOTHER/GUARDIAN INFORMATION**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Soc. Sec. #: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_\_\_ DOB:\_\_\_\_/\_\_\_\_/\_\_\_\_\_Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City State ZipHome Phone: ( ) \_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_\_Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City State ZipInsurance Co: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Policy/ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Type of Insurance: ⁮ HMO or ⁮ PPOIs preauthorization required for medical/diagnostic services? □ YES □ NODoes your plan cover prescription medications?* YES ⁮ NO

Does your plan require a second opinion BEFORE surgery?* YES ⁮ NO

Does your plan have DENTAL coverage?* YES ⁮ NO

Is your daughter covered under this policy? YES NO |

I authorize any insurance company, hospital, physician or other person who has attended/examined the claimant to disclose per request the release of all information with respect to any injury/illness, policy coverage, medical history, consultation, prescription, treatment, and/or all copies of medical records. A photocopy of this authorization shall be considered valid.

Parent Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_

Student Athlete: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_

Return this form to: Head Athletic Trainer Salem Academy & College 601 S. Church St. Winston-Salem, NC 27101