

Student Athlete Family Insurance Information and Record Release Form

16-17

Full Name of Student-Athlete: Sport:
SIU ID # Social Security # Date of Birth: Cell Phone:
Street Address:
City: State: Zip Code:

Father's Name: Social Security #
Father's Address: Date of Birth:
City: State: Zip Code:
Father's Phone (H): (C): (W):
Mother's Name: Social Security #
Mother's Address: Date of Birth:
City: State: Zip Code:
Mother's Phone (H): (C): (W):

- 1. Do you have health coverage for your daughter/son? Yes No
2. Does your hospitalization policy require that all in-patient confinements and all surgical procedures be pre-certified to be eligible for full benefits? Yes No
3. Does your policy contain a mandatory second surgical opinion requirement before a surgical procedure may be performed? Yes No
4. At what age does your insurance terminate for your daughter/son?

P Please Attach Copy of Insurance Card
R Health Insurance Company: Phone#
I Name of Employer (if group coverage):
M Group Policy # ID #:
A Member Name: Deductible Amount/Person:
R Insurance Co. Address: Policy Limit:
Y City: State: Zip Code:

S Please Attach Copy of Insurance Card
E Health Insurance Company: Phone#
C Name of Employer (if group coverage):
O Group Policy # ID #:
N Member Name: Deductible Amount/Person:
D Insurance Co. Address: Policy Limit:
A City: State: Zip Code:
R
Y

WE AUTHORIZE SOUTHERN ILLINOIS UNIVERSITY CARBONDALE TO RELEASE ANY AND ALL MEDICAL RECORDS, BILLS, AND MEDICAL INFORMATION TO MY INSURANCE COMPANY(IES) AND ANY INSURANCE COMPANY UNDER WHICH I AM ENTITLED TO BENEFITS
WE UNDERSTAND THAT SOUTHERN ILLINOIS UNIVERSITY CARBONDALE STUDENT-ATHLETES MUST ALSO CARRY THE SIUC EXTENDED MEDICAL BENEFITS PLAN, AND MAY NOT ASK FOR A REFUND ON THIS PLAN.
A PHOTOCOPY OF THIS AUTHORIZATION WILL BE AS VALID AS THE ORIGINAL.

ATHLETE'S SIGNATURE DATE
PARENT SIGNATURE DATE