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? _____

PRIMARY

Please Attach Copy of Insurance Card

Health Insurance Company: _____ Phone# _____

Name of Employer (if group coverage): _____

Group Policy # _____ ID #: _____

Member Name: _____ Deductible Amount/Person: _____

Insurance Co. Address: _____ Policy Limit: _____

City: _____ State: _____ Zip Code: _____

SECONDARY

Please Attach Copy of Insurance Card

Health Insurance Company: _____ Phone# _____

Name of Employer (if group coverage): _____

Group Policy # _____ ID #: _____

Member Name: _____ Deductible Amount/Person: _____

Insurance Co. Address: _____ Policy Limit: _____

City: _____ State: _____ Zip Code: _____

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_____