OTHER INSURANCE QUESTIONNAIRE

(THIS FORM SHOULD BE COMPLETED BY PARENTS PRIOR TO AN ATHLETE'S PARTICIPATION IN SPORTS AND KEPT ON FILE IN THE ATHLETIC DEPARTMENT IN THE EVENT OF A CLAIM)

NAME OF STUDENT_____ SOC SEC #_____

	FATHER	MOTHER
NAME	_____	_____
SOC SEC #	_____	_____
EMPLOYED	_____YES _____NO	_____YES _____NO
EMPLOYER	_____	_____
ADDRESS	_____	_____
	STREET	STREET
	_____	_____
	CITY STATE ZIP	CITY STATE ZIP
PHONE	_____	_____
CONTACT PERSON	_____	_____

DO YOU HAVE GROUP MEDICAL INSURANCE COVERAGE THROUGH YOUR EMPLOYMENT?

	_____YES _____NO	_____YES _____NO
INS. CO.	_____	_____
ADDRESS	_____	_____
	STREET	STREET
	_____	_____
	CITY STATE ZIP	CITY STATE ZIP
POLICY #	_____	_____

TYPE OF PLAN:
_____ HEALTH MAINTENANCE ORGANIZATION (HMO)
_____ PREFERRED PROVIDER ORGANIZATION (PPO)
_____ STANDARD MEDICAL & HOSPITALIZATION COVERAGE
_____ OTHER (DESCRIBE)

If you have medical insurance coverage, and your son/daughter is not covered or is partially covered due to policy limitations, please explain.

_____
_____
_____

If your son/daughter has medical insurance coverage as an eligible dependent from your previous marriage, as mandated in a divorce decree, please give details for filing a claim.

_____
_____
_____

I/WE AGREE THAT ALL INFORMATION PROVIDED IN THIS DOCUMENT IS ACCURATE AND COMPLETE TO THE BEST OF MY/OUR KNOWLEDGE. I/WE UNDERSTAND THAT ANY INCORRECT OR UNDISCLOSED INFORMATION CAN RESULT IN DUPLICATE PAYMENTS CREATING A SUBSTANTIAL OVERPAYMENT. THE RESPONSIBILITY OF SUCH OVERPAYMENT WILL BE THE OBLIGATION OF THE UNDERSIGNED TO REIMBURSE IN FULL, UPON REQUEST, ALL AMOUNTS DEEMED REFUNDABLE.

PARENT/GUARDIAN/FATHER_____ DATE_____

PARENT/GUARDIAN/MOTHER_____ DATE_____