



7400 College Blvd., Ste 100
Overland Park, KS 66210

STUDENT INFORMATION

Personal Information

Student Name _____ Social Security # _____
Address _____ Phone Number _____
Fathers Name _____ Mothers Name _____
Address _____
Phone Number _____
Fathers Employer Name _____
Mothers Employer Name _____
Primary Physician Name _____ Phone Number _____
Address _____

Insurance Information

Insurance Company Name _____
Address _____
Phone Number _____
Policy Holder Name _____ ID Number _____

I certify that the foregoing information is true and correct.

Student Signature _____ Date _____

Authorization to Release Information

I authorize any Health Care Provider, Insurance Company, Employer, Person or Organization to release information regarding medical, dental, mental, alcohol or drug abuse history, treatment or benefits payable, including disability or employment related information, to Summit America Insurance Services, L.C., the Plan Administrator, or their employees and authorized agents for the purpose of validating and determining benefits payable. A photocopy of this authorization shall be as valid as the original.

Signature _____ Date _____