

PARENT INFORMATION FORM

Graceland University: 2007-2008

FAILURE TO COMPLETE ALL BLANKS WILL RESULT IN CLAIMS PROCESSING DELAYS.

NOTE: Complete all blanks. If information is not applicable, indicate the reason it is not (e.g., deceased, divorced, unknown).

I. Name of Athlete: _____ Sport: _____
Social Security #: _____ Date of Birth: _____
College Address: _____ Phone: _____
Home Address: _____ Phone: _____
City: _____ State: _____ Zip: _____

II. Father/Guardian: _____ Mother/Guardian: _____
Social Security #: _____ Social Security #: _____
Address: _____ Address: _____
Telephone: _____ Telephone: _____

III. Employer: _____ Employer: _____
Telephone: _____ Telephone: _____

IV. Medical Insurance Company or Plan: _____ Medical Insurance Company or Plan: _____
Address: _____ Address: _____
Policy Number: _____ Policy Number: _____
Phone Number: _____ Phone Number: _____

Is the company or plan listed above considered a Health Maintenance Organization (HMO) or a Preferred Provider Organization (PPO) Yes _____ No _____
Is pre-authorization required to obtain treatment. Yes _____ No _____
Does your insurance or plan require a second opinion before surgery? Yes _____ No _____

I hereby authorize Graceland University to inspect or secure copies of case history records, laboratory reports, diagnoses, x-rays, and any other data covering this and /or previous confinements and/or disabilities. A photostatic copy of this authorization shall be deemed as effective and valid as the original.

We authorize that the college/university or its insurance agent pay the medical vendors direct for any bills incurred from accidents that are covered under the coverage purchased by the college/university.

Parent's Signature: _____
Student's Signature: _____