

INSURANCE INFORMATION

Student Name: _____ Date: _____

Name of Person insurance is under: _____

Address: _____

Home Phone: _____ Emergency Phone: _____

PRIMARY INSURANCE

Company: _____

Address: _____

Phone: _____

Employer name: _____ Phone: _____

Employer Address: _____

Employee ID#: _____ Plan Number: _____

Policy Number: _____

SECONDARY INSURANCE

Company: _____

Address: _____

Phone: _____

Employer Name: _____ Phone: _____

Address: _____

Employee ID#: _____ Plan Number: _____

Policy Number: _____

Is your medical coverage through a Health Maintenance Organization (HMO)? Yes ___ No ___

Is a referral needed? Yes ___ No ___

If yes, phone number to call for referral. _____

Is your medical coverage through a Preferred Provider Organization (PPO)? Yes ___ No ___

Is a referral needed? Yes ___ No ___

If yes, phone number to call for referral. _____

It is the students and/or parents responsibility to obtain any needed referrals. All students are responsible to know how there insurance works in this area and how to obtain a referral. They will need their own Insurance card or a copy.

Please attach a copy of your insurance card (front and back).

Parent/Guardian Signature: _____