



# INSURANCE INFORMATION FORM

This form must be completed, signed and returned to the Athletic Department prior to participation in any intercollegiate athletic activity. The College secures accident coverage that may be utilized only after family insurance is exhausted.

PLEASE PRINT

Athlete's Name \_\_\_\_\_ Sport(®) \_\_\_\_\_

Home Address \_\_\_\_\_  
Street City State Zip

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Father's Name \_\_\_\_\_ SS# \_\_\_\_\_

Home Address \_\_\_\_\_  
Street City State Zip

Home Phone ( ) \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_

Employer's Name \_\_\_\_\_

Employer's Address \_\_\_\_\_  
Street City State Zip

Name/Group Insurance Co. \_\_\_\_\_ Policy # \_\_\_\_\_

Mailing Address for Claims \_\_\_\_\_

Phone ( ) \_\_\_\_\_

- Is your dependent son/daughter covered under the above policy? ... ..  YES  NO
- Is your plan part of an HMO that restricts treatment outside the group? ... ..  YES  NO
- Does your plan require pre-authorization for services? ... ..  YES  NO

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Mother's Name \_\_\_\_\_ SS# \_\_\_\_\_

Home Address \_\_\_\_\_  
Street City State Zip

Home Phone ( ) \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_

Employer's Name \_\_\_\_\_

Employer's Address \_\_\_\_\_  
Street City State Zip

Name/Group Insurance Co. \_\_\_\_\_ Policy # \_\_\_\_\_

Mailing Address for Claims \_\_\_\_\_

Phone ( ) \_\_\_\_\_

- Is your dependent son/daughter covered under the above policy? ... ..  YES  NO
- Is your plan part of an HMO that restricts treatment outside the group? ... ..  YES  NO
- Does your plan require pre-authorization for services? ... ..  YES  NO

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\_\_\_\_\_  
PARENT SIGNATURE DATE

\_\_\_\_\_  
PARENT SIGNATURE DATE

**RETURN TO: Rosemont College, Athletic Department, 1400 Montgomery Avenue, Rosemont, PA 19010-1699**