Kent State University: Athletic Training

INSURANCE INFORMATION/EMERGENCY CONTACT FORM

Section **ONE**: **ATS or ATSA COMPLETE**

Name: _____ Banner ID # _____ Birthdate: _____

Home Address: _____ Home Phone: (____) _____
Street City State Zip

PARENT/GUARDIAN

Father's Name: _____ Birthdate: _____ Mother's Name: _____ Birthdate: _____

Address: _____ Address: _____
Street City State Zip Street City State Zip

Phone: (____) _____ Social Security # ____N/A_____ Phone: (____) _____ Social Security # _____N/A_____

Employer: _____ Occupation: _____ Employer: _____ Occupation: _____

Employer's Address: _____ Employer's Address: _____
Street City State Zip Street City State Zip

Work Phone: (____) _____ext. _____ Work Phone: (____)_____ext. _____

Section **TWO**: **PARENT, GUARDIAN, or SPOUSE COMPLETE**

Is this student covered at this time by your present surgical and hospital insurance policy?..... **Yes** _____ **No** _____
If yes, complete the following (list THE PHONE NUMBER(S), address, and all appropriate insurance policy numbers):

FATHER/GUARDIAN (Please Xerox front & back of card and Attach to Form)

Medical Insurance Co.: _____

Phone #: (____) _____ (____) _____

Address: _____
Street City State Zip

Policy #: _____ Certificate #: _____

Group #: _____ Additional #: _____

Primary Care Physician: _____ PCP Phone: (____)_____

Does this Insurance Plan require second opinion for surgery? **Yes/No** _____

MOTHER/GUARDIAN (Please Xerox front & back of card and Attach to Form)

Medical Insurance Co.: _____

Phone #: (____) _____ (____) _____

Address: _____
Street City State Zip

Policy #: _____ Certificate #: _____

Group #: _____ Additional #: _____

Primary Care Physician: _____ PCP Phone: (____)_____

Does this Insurance Plan require second opinion for surgery? **Yes/No** _____

Section **THREE**:

A. I hereby authorize Kent State University & its Insurance Carrier, to inspect or secure copies of any medical report covering injuries & disabilities. A photocopy of this authorization shall be deemed as effective and valid as the original.
B. I acknowledge receiving one copy of the Kent State University's Athletic Injury & Medical Policy.
C. I hereby authorize the provider(s) of medical services to release information regarding injury/disability and authorize payment of insurance benefits directly to the provider(s) of medical services, not to exceed provider's regular charges.

ATTACH A COPY OF THE INSURANCE CARD TO THIS DOCUMENT

_____ _____ _____ _____
Student's Signature Date Parent/Guardian/Spouse Signature Date
[**Preferable for Policyholder to sign]**