Academic Year: _____ Sport(s): _____

SOUTHWESTERN COLLEGE
MEDICAL INSURANCE INFORMATION/AUTHORIZATION

(Please Type or Print Clearly)

Personal Information

Athlete's Name: _____ Date of Birth:_____
Last First Middle

Social Security #: _____ Phone: _____

Home Address: _____ Phone: _____
Street/PO Box City State Zip

School Address: _____
Street/PO Box City State Zip

Medical Insurance Information **(This section must be completely filled out with a copy of your insurance card attached. You MUST have insurance coverage to participate in intercollegiate athletics at Southwestern College.**

Policy Holder Name: _____ Social Security #: _____

Address: _____ Phone: _____
Street/PO Box City State Zip

Employer: _____

Address: _____ Phone: _____
Street/PO Box City State Zip

Insurance Company: _____ Phone: _____

Address: _____
Street/PO Box City State Zip

Group #: _____ ID #: _____

Policy#:_____

Spouse: _____ Social Security #: _____

Employer: _____ Phone: _____

Address: _____
Street/PO Box City State Zip
(If different from above)

Insurance Company: _____ Phone: _____

Does the above mentioned policy cover the following?
(circle one)

Prescription Yes No
Dental Yes No
Optical Yes No

Does this policy require pre-authorization for medical care? Yes No
Does this policy require pre-authorization for surgery? Yes No
Does this policy have a designated primary care physician? Yes No

Physician Name:_____ Phone: _____

Address: _____
Street/PO Box City State Zip

I have read the athletic injury medical insurance policy information and understand the statements contained therein. In the event the above student-athlete sustains an athletic injury or illness, the Southwestern athletic training/sports medicine department is hereby authorized to file a claim on my behalf under the above medical insurance policy.

Signature of Policy Holder: _____ Date: _____
Signature of Student-Athlete: _____ Date: _____

Return to: Athletic Training Staff; Southwestern College
100 College Street, Winfield KS 67156