HEALTH INSURANCE INFORMATION REPORT

ALL STUDENTS MUST COMPLETE AND RETURN THIS FORM BEFORE *AUGUST 15*

This information is ***required each year*** and is vital in the event your son is injured or becomes ill while at Wabash College. **Failure to complete all blanks will result in claims processing delays as well as blocked academic records.** Mail to: Student Health Services
Wabash College
P.O. Box 352
Crawfordsville, IN 47933

Date ______________________

A. Personal Information

Student's Name ____

Year in School ____________________ Date of Birth ____________________ Email ______________________________

College Address ______________________________ Students Phone ______________________________

Home Address ______________________________ Home Phone ______________________________

City ____________________ State ______ Zip Code ____________ Cell Phone ______________________________

Collegiate Sport(s) ____ No Sport ______________

Name of family physician: ______________________________________ Phone: ______________________

In case of emergency, notify:

Name ______________________________________ Phone (day) ______________ (night) ______________

Address ______________________________________ Relationship ______________________

City ______________________________________ State __________ Zip Code ______________

B. Insurance Information ***[______] The above named student does not have medical insurance***

Policy Holder Name: ______________________________________ Relationship to Student: ______________

Date of Birth: ______________ SSN#: ______________ Cell Phone ______________________________

Home Address: ______________________________ Home Phone ______________________________

City: ________________________ State _________ Zip ______________

Employer ______________________________________ Work Phone ______________________________

Insurance Company ______________________________ Insurance Phone ______________________________

Address ______________________________________

City ________________________ State _______ Zip _______

Policy Number ______________________________________

Plan Number ______________________________________

If the student is covered under any other insurance policy please copy and label those insurance cards and attach to this form. **If at any time during the year, the primary insurance carrier changes please send front and back copy of new insurance card.**

HMO _____ PPO _____ 2nd Opinion Required? Yes __ No____ Coverage out of State? Yes ____ No ____

Pre-authorization needed? Yes _____ No ______ Per-authorization Phone ______________________________

<u>Please include front and back copy of current insurance card</u>.

Does this policy cover your son while participating in intercollegiate sports? Yes ___No___

FOR STUDENT ATHLETES:

Note to HMO or PPO subscribers: For the parents to have payable coverage on their sons (when a member of these insuring organizations) they must use the authorized medical vendors from the list provided them. The Athletic Insurance coverage is EXCESS coverage and contains an exclusion for those bills incurred that were payable by the primary insurance (HMO or PPO). If the parents or students choose not to use authorized medical vendors of their plan, the Wabash Athletic Insurance will not pay the bills incurred that would have been honored had the student used the proper medical vendors.

I hereby authorize Wabash College and Student Athletic Protection, Inc. of Kalamazoo, MI 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 photo static copy of this authorization shall be deemed as effective as the original and valid up to two years from the date of signature.

C. Signatures [REQUIRED]

We authorize Wabash College or its insurance agent to pay the medical vendors directly for any bills incurred from intercollegiate athletic accidents.

Student's Signature ____ Date ______________

Parent's Signature ____ Date ______________

If at any time during the year, the primary insurance carrier changes please send front and back copy of new insurance card.