

PARENT INFORMATION FORM

**PARENTS/GUARDIANS TO COMPLETE AND RETURN TO: ATTN: TONY GAMBILL
HEAD ATHLETIC TRAINER
UNIVERSITY OF ST. FRANCIS
2701 SPRING STREET
FORT WAYNE, IN 46808**

**FAILURE TO COMPLETE ALL BLANKS WILL RESULT IN CLAIMS PROCESSING DELAYS.
NOTE: If information is not applicable, indicate the reason it is not, i.e. deceased, divorced, married,
not under parent's insurance, etc.**

Name of Athlete: _____ Sport: _____

Student ID # (If known): _____ Date of Birth: _____

Address (at College): _____

Home Phone: (____) _____ Cell Phone: (____) _____

Home Address: _____

City: _____ State: _____ Zip: _____

Father/Guardian: _____ Mother/Guardian: _____

Date of Birth: _____ Date of Birth: _____

Social Security Number: _____ Social Security Number _____

Address: _____ Address: _____

Employer: _____ Employer: _____

Address: _____ Address: _____

Phone: (____) _____ Phone: (____) _____

Medical Insurance Co.: _____ Medical Insurance Co.: _____

Address: _____ Address: _____

Policy Number (*Not Group*): _____ Policy Number (*Not Group*): _____

Phone: (____) _____ Phone: (____) _____

Is the company or plan listed above considered a Health Maintenance Organization (HMO) or a Preferred Provider Organization (PPO)? Yes _____ No _____

Does your insurance or plan require a second opinion before surgery? Yes _____ No _____

PLEASE CONTINUE ON OTHER SIDE OF THIS FORM

I hereby authorize any hospital, physician, employer, or any other person who has attended or examined the Student to disclose, when requested to do so, any information to SUMMIT AMERICA INSURANCE SERVICES with respect to any injury, policy coverage, medical history, consultations, prescription or treatment, and copies of all hospital or medical records and itemized bills. A photostatic copy of this authorization shall be considered as effective and valid as the original. I swear that the above information is true and correct to the best of my knowledge and further understand that it is a criminal offense to knowingly file a statement of claim containing false or misleading information or to willfully conceal information thereto with the intent to defraud an insurance company. I also authorize payment directly to the Provider of service for medical benefits, otherwise payable to me for services rendered but not exceed the reasonable and customary charge for those services.

Student's Signature: _____ Date _____

Parent's Signature: _____ Date _____

(If athlete is under 18)