

**Shawnee State University  
Insurance Information Form**

*\*This form will travel with the athlete to physician appointments, away contests, and will be on file in the Shawnee State University Athletic Training Room.*

*\*\*Failure to complete this form will result in claims processing delays.*

*\*\*\*Place N/A in blanks if the information is not applicable.*

**1. Full Name of Athlete:** \_\_\_\_\_ **Sport:** \_\_\_\_\_

**Permanent/Home Address:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_

**Campus Address:** \_\_\_\_\_ **Campus Phone:** \_\_\_\_\_

**Athletes Mobile Phone:** \_\_\_\_\_

**2. Father/Guardian Full Name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **Mobile Phone:** \_\_\_\_\_

**City** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_

**Employer:** \_\_\_\_\_ **Employer Phone:** \_\_\_\_\_

**\*DO YOU HAVE GROUP MEDICAL COVERAGE FOR THIS DEPENDANT THROUGH YOUR EMPLOYER?**

**YES** \_\_\_\_\_ **NO** \_\_\_\_\_

**Name of Insurance Company:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Insurance Company Address:** \_\_\_\_\_

**Policy Number:** \_\_\_\_\_ **Group Number:** \_\_\_\_\_

**3. Mother/Guardian Full Name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **Mobile Phone:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_

**Employer:** \_\_\_\_\_ **Employer Phone:** \_\_\_\_\_

**\*DO YOU HAVE GROUP MEDICAL COVERAGE FOR THIS DEPENDANT THROUGH YOUR EMPLOYER?**

**YES** \_\_\_\_\_ **NO** \_\_\_\_\_

**Name of Insurance Company:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Insurance Company Address:** \_\_\_\_\_

**Policy Number:** \_\_\_\_\_ **Group Number:** \_\_\_\_\_

**4. Are there any other medical insurance policies covering this athlete?** **YES** \_\_\_\_\_ **NO** \_\_\_\_\_

**(If yes) Name of Insurance Company:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Insurance Company Address:** \_\_\_\_\_

**Policy Number:** \_\_\_\_\_ **Group Number:** \_\_\_\_\_

**5. Emergency Contact Information**

**Contact 1:** \_\_\_\_\_ **Phone:** \_\_\_\_\_ **Mobile Phone:** \_\_\_\_\_

**Contact 2:** \_\_\_\_\_ **Phone:** \_\_\_\_\_ **Mobile Phone:** \_\_\_\_\_

I hereby authorize Shawnee State University and Summit America Insurance 7400 College Boulevard, Suite 100 Overland Park, Kansas 66210 to inspect or secure copies of case history records, laboratory reports, diagnosis, x-rays, and any other data covering confinements and/or disabilities.

A photostatic copy of this authorization shall be deemed as effective and valid as the original. We authorize that Shawnee State University or its insurance agent ( Summit America) pay the medical vendors direct for any bills incurred from accidents that are covered under the coverage purchased by Shawnee State University.

**Parent's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Student Athlete's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_