

**Shawnee State University
Insurance Information Form**

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

1. Full Name of Athlete: _____
Sport: _____ **Phone:** _____
Permanent/Home Address: _____
City: _____ **State:** _____ **Zip Code:** _____
Campus Address: _____
Campus/Mobile Phone: _____

2. Mother/Guardian Full Name: _____
Address: _____
City _____ **State:** _____ **Zip Code:** _____
Phone: _____
Mobile Phone: _____
Employer: _____

Employer Phone: _____
***DO YOU HAVE GROUP MEDICAL COVERAGE FOR THIS DEPENDANT THROUGH YOUR EMPLOYER?**

YES _____ **NO** _____

Name of Insurance Company: _____
Phone of Insurance Company: _____
Insurance Company Address: _____

Policy Number: _____ **Group Number:** _____

3. Father/Guardian Full Name: _____
Address: _____
City _____ **State:** _____ **Zip Code:** _____
Phone: _____
Mobile Phone: _____
Employer: _____

Employer Phone: _____
***DO YOU HAVE GROUP MEDICAL COVERAGE FOR THIS DEPENDANT THROUGH YOUR EMPLOYER?**

YES _____ **NO** _____

Name of Insurance Company: _____
Phone of Insurance Company: _____
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 of Insurance Company: _____
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.

Student Athlete's Signature: _____

Date: _____

Parent's Signature: _____

Date: _____