

Insurance Questionnaire

This form should be completed **in full** by the parents or the primary insurance provider prior to participation in athletics at Baker University and kept on file in the Sports Medicine Department in the event of a serious injury or medical insurance claim.

Name of Student _____ Sport _____ Date of Birth _____

Father / Mother

Name _____

Employed _____ Yes _____ No

Address _____

Phone (____) _____

Do you have GROUP medical insurance coverage through your employment? _____ Yes _____ No

Ins. Co. _____

Address _____

Policy/Group No. _____

Claims Phone (____) _____

Pre-Auth. Required? _____ Yes _____ No

2nd Opinion/Surgery? _____ Yes _____ No

Type of Plan:

_____ Health Maintenance Organization (HMO)

_____ Preferred Provider Organization (PPO)

_____ Standard Medical/Hospital Coverage

_____ Other:

Please Copy and Tape the Student Athlete's Insurance Card:

FRONT

BACK

If you have medical insurance coverage, and your son/daughter is NOT covered or is PARTIALLY covered due to policy limitations, please explain:

If your son/daughter has medical insurance as an eligible dependent from your previous marriage, as mandated in a divorce decree, please give details for filing a claim:

I/we agree that all information provided in this document is accurate and complete to the best of my/our knowledge. I/we understand that any incorrect or undisclosed information can result in duplicate billing/payment. The responsibility of such overpayment will be the obligation of the undersigned to reimburse in full, upon request, all amounts deemed refundable.

Student Athlete _____

Parent/Guardian (if under 18) _____

Date _____

Date _____

Revised 3/2011