

# CLARKE COLLEGE ATHLETIC INSURANCE FORM

**PARENTS/POLICYHOLDER PLEASE COMPLETE AND RETURN TO:**

**6-1-09**

Clarke College, Attn: Athletic Department, 1550 Clarke Dr. MS 1756, Dubuque, IA 52001

Fax 563-588-6666. **NO ATHLETE WILL BE ALLOWED TO PARTICIPATE OR PRACTICE**

**UNTIL THIS FORM IS COMPLETED AND SIGNED BY A POLICY HOLDER AND ON FILE IN THE ATHLETIC OFFICE.**

Name of Athlete \_\_\_\_\_ SS# \_\_\_\_\_  
Sport(s) \_\_\_\_\_ Phone \_\_\_\_\_  
Address \_\_\_\_\_ Birthdate \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Gender \_\_\_\_\_  
Campus Phone \_\_\_\_\_ Cell \_\_\_\_\_

Father/Guardian/Spouse \_\_\_\_\_ Mother/Guardian/Spouse \_\_\_\_\_  
Address \_\_\_\_\_ Address \_\_\_\_\_  
City/state/zip \_\_\_\_\_ City/State/Zip \_\_\_\_\_  
Employer's Name \_\_\_\_\_ Employer's Name \_\_\_\_\_  
Employer's Address \_\_\_\_\_ Employer's Address \_\_\_\_\_  
Home Phone \_\_\_\_\_ Home Phone \_\_\_\_\_  
Cell \_\_\_\_\_ Cell \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Date of Birth \_\_\_\_\_

Medical Insurance \_\_\_\_\_ Medical Insurance \_\_\_\_\_  
Policyholder Name \_\_\_\_\_ Policyholder Name \_\_\_\_\_  
Insurance Name \_\_\_\_\_ Insurance Name \_\_\_\_\_  
Claims Address \_\_\_\_\_ Claims Address \_\_\_\_\_  
Policy/Plan Number \_\_\_\_\_ Policy/Plan Number \_\_\_\_\_  
Group Number \_\_\_\_\_ Group Number \_\_\_\_\_  
Phone \_\_\_\_\_ Phone \_\_\_\_\_

**HMO or PPO?** \_\_\_\_\_ **HMO or PPO?** \_\_\_\_\_  
Cover son or daughter? (Y/ N) \_\_\_\_\_ Cover son or daughter? (Y/N) \_\_\_\_\_  
Second opinion for surgery?(Y/N) \_\_\_\_\_ Second opinion for surgery? (Y/ N) \_\_\_\_\_  
Primary Physician \_\_\_\_\_ Phone \_\_\_\_\_  
Emergency Room Preferred FINLEY, MERCY or EITHER \_\_\_\_\_

Authorization from insurance required before seeing specialist?(Y/N) \_\_\_\_\_

**Please list specialty physicians below your insurance allows you to see in Dubuque:**

Family Practitioner \_\_\_\_\_ Ophthalmology \_\_\_\_\_  
(List practice name if all doctors apply) \_\_\_\_\_ Pulmonology \_\_\_\_\_  
Insurance website address: \_\_\_\_\_  
Orthopedic \_\_\_\_\_ Neurologist \_\_\_\_\_  
Dental \_\_\_\_\_ Pharmacy \_\_\_\_\_  
Ear, Nose, Throat \_\_\_\_\_ Cardiologist \_\_\_\_\_

**If there are no physicians for any of the above areas in Dubuque covered by your insurance please list procedures to be taken if the above specialist are needed.**

**For example - "Contact emergency room," "Call parents"**

I hereby authorize Clarke College and First Agency of Kalamazoo, Michigan to inspect or secure copies of all medical records and any data relating to injury. A photostatic copy of this authorization shall be deemed as effective and valid as the original. I certify that the answers provided are true, complete, and correct to the best of my knowledge. Please notify the Athletic Training Department of an changes immediately.

Signature of athlete \_\_\_\_\_ Date \_\_\_\_\_  
Signature of policyholder (required) \_\_\_\_\_ Date \_\_\_\_\_