



06-07

**Averett University
Student-Athlete Insurance Information**

Please complete the following as thorough as possible. Any blanks may result in delays of procession insurance claims. All information provided here will be held strictly confidential.

Please Print

Student-Athlete _____ Male/Female Sport _____
Last First MI

Home Address _____ City/State/Zip _____

Date of Birth _____ SS# _____ Year of Eligibility Fr So Jr Sr 5th year

Home Phone () _____ Mobile Phone () _____ Email _____

Parent/Guardian Information (Primary Insurer)		Other Father/Mother/Guardian Information	
Policy Holder Name		Policy Holder Name	
Relationship to Athlete		Relationship to Athlete	
Social Security Number of Policyholder		Social Security Number of Policyholder	
Date of Birth of Policyholder		Date of Birth of Policyholder	
Home Address		Home Address	
City, State, Zip		City, State, Zip	
Home Phone ()	Cell Phone ()	Home Phone ()	Cell Phone ()
Name of Employer of Policy Holder		Name of Employer of Policy Holder	
Address of Employer		Address of Employer	
City, State, Zip		City, State, Zip	
Work Phone		Work Phone	
Email Address		Email Address	
PRIMARY INSURANCE COMPLETE THIS SECTION AND TAPE A COPY OF THE INS. CARD TO THE BACK OF THIS FORM		SECONDARY INSURANCE COMPLETE THIS SECTION AND TAPE A COPY OF THE INS. CARD TO THE BACK OF THIS FORM	
Name of Insurance Company		Name of Insurance Company	
Street Address		Street Address	
City, State, Zip		City, State, Zip	
Phone		Phone	
Policy Number		Policy Number	
Group Number		Group Number	
This policy is an HMO PPO Other If HMO Primary Phycian: _____ Primary Phycian Phone: _____		This policy is an HMO yes no If HMO Primary Phycian: _____ Primary Phycian Phone: _____	
This policy requires pre-authorization? yes no If yes, list phone number: _____		This policy requires pre-authorization? yes no If yes, list phone number: _____	
Does your insurance provide dental benefits? Yes No		Does your insurance provide dental benefits? Yes No	



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Pleas attach a copy of the insurance card on the appropriate box with tape (DO NOT STAPLE). Failure to do so will result in an incomplete insurance form and student-athlete ineligibility until a complete form is turned in.

<p style="text-align: center;">FRONT OF INSURANCE CARD</p>	<p style="text-align: center;">BACK OF INSURANCE CARD</p>
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I hereby authorize any licensed physician or hospital that has treated or attended the above claimant to furnish the insurance company or its representatives any information requested for completion of a claim. A Photostat of this authorization shall be considered as effective and valid as the original. I certify to the best of my knowledge the above information is accurate and will notify the Athletic Training Department of any changes if they occur during the upcoming academic year.

Signature of Parent-Guardian _____ Date _____

Signature of Student-Athlete _____ Date _____