

**Louisburg College**  
**Medical Insurance Information**

Athlete's Name \_\_\_\_\_ SS# \_\_\_\_\_ DOB \_\_\_\_\_  
Sex \_\_\_\_\_ Sport \_\_\_\_\_ Home Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone \_\_\_\_\_  
Cell Phone \_\_\_\_\_

**Primary Insurance**

Parent/Guardian \_\_\_\_\_ SS# \_\_\_\_\_ DOB \_\_\_\_\_  
Home Address \_\_\_\_\_  
State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone Number \_\_\_\_\_  
Employer \_\_\_\_\_ Phone # \_\_\_\_\_  
Employer Address \_\_\_\_\_  
Insurance Co. \_\_\_\_\_ Phone # \_\_\_\_\_  
Claims Address \_\_\_\_\_  
Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_  
Is your son/daughter covered under the above policy? Yes No  
Type of Coverage: (circle one) Does your insurance require?  
Health Maintenance Organization(HMO) \_\_\_\_\_ Second Opinion for surgery Yes No  
Preferred Provider (PPO) \_\_\_\_\_ Pre authorization Yes No  
Comprehensive Plan \_\_\_\_\_  
Other(please list): \_\_\_\_\_  
Primary Care Physician and Phone # \_\_\_\_\_

**Secondary Insurance**

Parent/Guardian \_\_\_\_\_ SS# \_\_\_\_\_ DOB \_\_\_\_\_  
Home address \_\_\_\_\_  
Home phone number \_\_\_\_\_  
Employer \_\_\_\_\_ Phone # \_\_\_\_\_  
Employer address \_\_\_\_\_  
Insurance Co \_\_\_\_\_ Phone # \_\_\_\_\_  
Claims Address \_\_\_\_\_  
Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_  
Is your son/daughter covered under the above policy? Yes No  
Type of Coverage: (circle one) Does your insurance require?  
Health Maintenance Organization(HMO) \_\_\_\_\_ Second Opinion for surgery Yes No  
Preferred Provider (PPO) \_\_\_\_\_ Pre authorization Yes No  
Comprehensive Plan \_\_\_\_\_  
Other(please list): \_\_\_\_\_

**Dental-Eye or Other Insurance Coverage**

Parent/Guardian \_\_\_\_\_ SS# \_\_\_\_\_  
Insurance Co \_\_\_\_\_ Phone # \_\_\_\_\_  
Claims Address \_\_\_\_\_  
Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_

Is your son/daughter covered under the above policy? Yes No

I hereby authorize the physician(s) rendering service to submit a claim to my Health Insurance Company for all covered services rendered by the physician(s) and direct the Health Insurance Company to issue payment check(s) directly to the physician signing this report to furnish complete information on my Health Insurance Company regarding service rendered, and I hereby claim the amount of indemnity specified with my Health Insurance Company.

• \_\_\_\_\_  
Signature of Policyholder(s) \_\_\_\_\_ Date \_\_\_\_\_

**Please include a photocopy of front and back of insurance cards**