

OLIVET COLLEGE

INSURANCE INFORMATION FORM

Note: Complete all blanks on this form. Failure to complete all blanks will result in claims processing delays.
 If information is not applicable, indicate the reason it is not (e.g. deceased, divorced, unknown).

Name of Athlete _____ Sport _____
 Social Security No. or Passport No. _____ Date of Birth _____
 College Address _____ College Phone (____) _____
 Home Address _____ Home Phone (____) _____
 City _____ State _____ Zip _____

I agree that the following insurance information is correct and current. I am aware it is my responsibility to notify the Wellness Center of any changes in this coverage. Signature of student _____

FATHER/GUARDIAN INFORMATION

MOTHER/GUARDIAN INFORMATION

Father's Name _____
 Date of Birth _____
 Address _____

Mother's Name _____
 Date of Birth _____
 Address _____

Employer _____
 Address _____

 Telephone (____) _____

Employer _____
 Address _____

 Telephone (____) _____

Medical Insurance
 Company or Plan _____
 Address _____

Medical Insurance
 Company or Plan _____
 Address _____

Policy Number _____
 Group # _____
 Telephone (____) _____

Policy Number _____
 Group # _____
 Telephone (____) _____

STUDENT INSURANCE INFORMATION

Medical Insurance Company _____
 Address _____ City _____ State _____ Zip _____
 Telephone # _____

Policy, Contract, or ID# _____
 Group # _____

Is Student's Primary Insurance Plan an HMO or PPO? Yes _____ No _____
 Is pre-authorization required to obtain treatment? Yes _____ No _____
 Is a second opinion required before surgery? Yes _____ No _____

PRIMARY CARE PHYSICIAN _____ PHONE _____
 Address _____