Andrew College
Athletic Insurance Questionnaire

Attach a photocopy (front & back) of your
Health Insurance Card/ Prescriptions Benefit Card

Name: _____ Social Security Number: _____

Date of Birth: _____ Athlete's Cell Number: _____

Insurance Holder for Athlete

Name: _____

Date of Birth: _____ Social Security Number: _____

Employer: _____

Employer Address: _____

Telephone: _____

Is the student-athlete insured? _____yes _____no

Insurance Co: _____

Address: _____

Telephone _____Does the plan require a second opinion before surgery? ____Yes ____No

Policy # _____ Group # _____

Does the plan cover your son or daughter during their sport season? ____Yes ____No

Type of Plan:
___ Health Maintenance Plan (HMO) ___ Preferred Provider Organization (PPO)
___Standard Medical and Hospitalization ___ Other (Describe) _____

If your son/daughter has medical 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 payments creating a substantial overpayment. The responsibility of such overpayment will be the obligation of the undersigned to reimburse in full upon request, all amounts deemed refundable.

Father/Guardian: _____ Date: _____

Mother/Guardian: _____ Date: _____