

PARENT INFORMATION FORM

M-09/10

PARENTS/GUARDIAN TO COMPLETE AND RETURN TO:
FAX- (704) 406-3503
Attn: Jon Mitchell, Service Program Director

Gardner-Webb University
Athletic Training
P.O. Box 877
Boiling Springs, NC 28017

FAILURE TO COMPLETE ALL BLANKS WILL RESULT IN CLAIMS PROCESSING DELAYS. NOTE: Complete all blanks. If information is not applicable, indicate the reason it is not (e.g., deceased, divorced, unknown).

I. Name of Athlete: _____ Sport: _____
Social Security #: _____ Date of Birth: _____
GWU Campus Box: _____ Phone: _____
Home Address: _____ Phone: _____
City: _____ State: _____ Zip: _____

II. Father/Guardian: _____ Mother/Guardian: _____
Social Security #: _____ Social Security #: _____
Date of Birth: _____ Date of Birth: _____
Address: _____ Address: _____

III. Employer: _____ Employer: _____
Address: _____ Address: _____
Telephone: _____ Telephone: _____

IV. Medical Insurance Company or Plan _____ Medical Insurance Company or Plan _____
Address: _____ Address: _____

Policy Number: _____ Policy Number: _____
Policy Effective Dates: _____ Policy Effective Dates: _____
Policy Deductibles/Co-insurance: _____ Policy Deductibles/Co-insurance: _____
Phone Number: _____ Phone Number: _____

Is the company or plan listed above considered a Health Maintenance Organization (HMO) or a Preferred Provider Organization (PPO)? Yes No
If yes, please circle which type of Plan you have: HMO PPO

Is pre-authorization required to obtain treatment? Yes No
Does your insurance or plan require a second opinion before surgery? Yes No
Does your insurance or plan cover athletic injuries? Yes No
Does your insurance or plan provide out-of-state or out-of-network benefits? Yes No

I hereby authorize Gardner-Webb University to inspect or secure copies of case history records, laboratory reports, diagnoses, x-rays, and any other data covering this and/or previous confinements and/or disabilities. A photostatic copy of this authorization shall be deemed as effective and valid as the original. We authorize that the university or its insurance agent pay the medical vendors direct for any bills incurred from accidents that are covered under the coverage purchased by the university.

Parent's Signature: _____

Student's Signature: _____