



Grand Valley State University Athletic Department

Medical Insurance Information Form

84 Fieldhouse, Allendale, MI 49401
Phone: 616-331-3329 Fax: 616-331-3232

08-09

Section 1: Student Athlete Information

First Name _____ Middle Initial _____ Last Name _____

Social Security # _____ Date of Birth _____

Address _____
while at school _____ Phone _____

_____ Sport _____

Section 2: Policy Holder Information

First Name _____ Middle Initial _____ Last Name _____

Social Security # _____ Date of Birth _____

Address _____ Phone _____

_____ Sport _____

This policy holder is the student's

Parent/Guardian _____ Self _____
Spouse _____ Other _____

Employer Address _____ Work Phone _____

Section 3: Primary Care Physician

First Name _____ Last Name _____

Address _____ Phone _____

Section 4: Medical Policy Information

Insurance Company _____

Group Number _____ Member Number _____

Coverage Code _____ Contract Code _____

Policy Number _____

Address _____ Phone _____

Plan Number _____

Enrollment Code _____

Policy Type
HMO Traditional
PPO Other _____
PPOM
Prescription Coverage?
Yes No
Effective Date _____

What are the limits of your insurance dollars? _____

Are sports injuries excluded from your coverage plan? Yes No

Attach copy of the front of medical insurance here.

Attach copy of the back of medical insurance here.

I understand that the information provided in this document will be used as the primary insurance in the event of an injury or illness related to participation in Intercollegiate Athletics at Grand Valley State University. I authorize the insurance company listed in section 3 or 4 to release any information to Grand Valley State University's Athletic Training Staff as required in applying for health care services or payment on my behalf. I authorize the medical providers to whom I am referred by Grand Valley State University's Athletic Department or such other medical providers to whom I am referred by the initial referral source for x-ray, laboratory or other diagnostic or therapeutic services to release any information required in applying for payment on my behalf and I hereby assign payment to these medical vendors for all services that these same medical vendors may render. I have received, read, understand and agree to the medical policies and procedures for the Grand Valley State University Athletic Medicine Department as a condition of eligibility for GVSU athletic participation. I understand my responsibilities and the University's responsibilities in the event a student athletic suffers an injury related to participation in intercollegiate athletics.

A copy of this authorization shall be deemed as effective and valid as the original and remain effective for one year from the date signed below.

Signature of Policy Holder

Date

Signature of Student Athlete

Date