



# Grand Valley State University Athletic Department

## Secondary 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 \_\_\_\_\_

Address while at school \_\_\_\_\_ Phone \_\_\_\_\_  
\_\_\_\_\_

Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_

Sport \_\_\_\_\_  
\_\_\_\_\_

### Section 2: Policy Holder Information

First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Last Name \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_  
\_\_\_\_\_

Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_

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 \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_  
\_\_\_\_\_

Group Number \_\_\_\_\_ Member Number \_\_\_\_\_

Plan Number \_\_\_\_\_

Policy Type

Coverage Code \_\_\_\_\_ Contract Code \_\_\_\_\_

Enrollment Code \_\_\_\_\_

HMO Traditional  
PPO Other \_\_\_\_\_  
PPOM

Policy Number \_\_\_\_\_

Prescription Coverage?

What are the limits of your insurance dollars? \_\_\_\_\_

Yes No

Are sports injuries excluded from your coverage plan? Yes No

Effective Date \_\_\_\_\_

Attach copy of the front of secondary medical insurance here.

Attach copy of the back of secondary 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