SAINT LOUIS UNIVERSITY SPORTS MEDICINE
Student/Family Information Form

IMPORTANT NOTICE: The student accident insurance plan is designed to offer maximum financial protection at minimum cost. In order to maintain this balance of cost and adequate protection, the plan does not allow us to provide benefits for certain losses that are collectible from other insurance. This provision greatly reduces costs by not duplicating coverage that you already have in effect. Please attach a copy of your insurance card to this form.

School **Saint Louis University** Address **3330 Laclede Avenue, St. Louis, MO 63103** Phone **314-977-3295**

Student ______________________________ Sport ______________
Last Name First Name Middle Initial

Banner ID # ______________ Sex ❑ F ❑ M Birthdate ______________

School Address ______________ City/State/Zip ______________

Home Address ______________ City/State/Zip ______________

School Phone ______________ Home Phone ______________

ALL SAINT LOUIS UNIVERSITY STUDENTS MUST HAVE PRIMARY HEALTH INSURANCE

Father's Name ______________

Father's Address (___ same as above) ______________

____

City/State/Zip ______________

Father's Employer ______________

Business Phone ______________

Employer's Address ______________

City/State/Zip ______________

Name and Address of Insurance Company

____

____

City/State/Zip ______________

Policy Number ______________

Company Phone ______________

Is the student covered? .... ___ YES ___ NO

Is the plan considered a HMO or PPO? .... ___ YES ___ NO

If yes, who is your primary physician? ______________

Primary Physician Phone ______________

Provider Number ______________

Is pre-certification required for treatment? .... ___ YES ___ NO

Is pre-certification required for hospitalization? .... ___ YES ___ NO

If yes, who is your primary physician? ______________

Mother's Name ______________

Mother's Address (___ same as above) ______________

____

City/State/Zip ______________

Mother's Employer ______________

Business Phone ______________

Employer's Address ______________

City/State/Zip ______________

Name and Address of Insurance Company

____

____

City/State/Zip ______________

Policy Number ______________

Company Phone ______________

Is the student covered? .... ___ YES ___ NO

Is the plan considered a HMO or PPO? .... ___ YES ___ NO

If yes, who is your primary physician? ______________

Primary Physician Phone ______________

Provider Number ______________

Is pre-certification required for treatment? .... ___ YES ___ NO

Is pre-certification required for hospitalization? .... ___ YES ___ NO

If yes, who is your primary physician? ______________

Do you understand that you must furnish, with claims, a statement from your other insurance company indicating their allowable benefits or their reason for refusal to pay? Your claims may be held pending receipt of this information .... ___ YES ___ NO

AFFIDAVIT: I verify that the above statement on other insurance is accurate and complete. I understand that the intentional furnishing of incorrect information via the US Mail may be fraudulent and violate federal laws as well as state laws. I agree that if determined at a later date that there are insurance benefits collectible on claims, I will reimburse the student accident insurance company to the extent for which they would not have been liable.

Signature ______________ Date ______________
Student (Parent/Guardian if under 18 years of age)

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance company, or other organization, institution, or person that has any records or knowledge of the student's health, to give information to the insurance company. To facilitate rapid submission of such information, I authorize all said sources to give such records or knowledge to any agency employed by the insurance company to collect and transmit such information. I understand that false or incomplete claim information will prolong claim benefit determination. A photocopy of this authorization shall be as valid as the original.

Signature ______________ Date ______________
Student (Parent/Guardian if under 18 years of age)