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.*

(1) School: Saint Louis University (2) Address: 3672 W. Pine Mall, St. Louis, MO 63108 (3) Phone: (314) 977-3295

(4) Student: _____ Sport: _____
(Last Name) (First Name) (Middle Initial)

(5) Student's Social Security No.: _____ (6) Birthdate: _____ (7) 1___ Male 2 ___ Female

Campus Address: _____ City/State: _____ ZIP: _____

Permanent Address: _____ City/State: _____ ZIP: _____

Mobile Telephone: _____ Permanent Telephone: _____ MSC #: _____

ALL SAINT LOUIS UNIVERSITY STUDENTS MUST HAVE PRIMARY HEALTH INSURANCE

(17) Father's Name: _____
Father's Social Security No.: _____
(19) Address (___ same as above) E-mail: _____
_____
City/State: _____ ZIP: _____
(20) Father's Employer: _____
Business Telephone: _____
(21) Employer's Address: _____
City/State: _____ ZIP: _____
(22) Name and Address of Insurance Company:
_____
_____
City/State: _____ ZIP: _____
(23) Policy Number: _____
Group Number: _____
Company Telephone: _____
Is the student covered? 8 ___ Yes 9 ___ No
Is the plan considered a HMO or PPO? ___ Yes ___ No
If yes, who is your primary physician? _____
Primary physician's telephone: _____
Provider number: _____
Is pre-certification required for treatment? ___ Yes ___ No
Is pre-certification required for hospitalization? ___ Yes ___ No
Policy effective date: _____ Expiration date: _____
Does it cover athletically-related injuries? ___ Yes ___ No
Policy Limit: $ _____
Deductible: $ _____ Copay: $ _____

(18) Mother's Name: _____
Mother's Social Security No.: _____
(19) Address (___ same as above) E-mail: _____
_____
City/State: _____ ZIP: _____
(20) Mother's Employer: _____
Business Telephone: _____
(21) Employer's Address: _____
City/State: _____ ZIP: _____
(22) Name and Address of Insurance Company:
_____
_____
City/State: _____ ZIP: _____
(23) Policy Number: _____
Group Number: _____
Company Telephone: _____
Is the student covered? 8 ___ Yes 9 ___ No
Is the plan considered a HMO or PPO? ___ Yes ___ No
If yes, who is your primary physician? _____
Primary physician's telephone: _____
Provider number: _____
Is pre-certification required for treatment? ___ Yes ___ No
Is pre-certification required for hospitalization? ___ Yes ___ No
Policy effective date: _____ Expiration date: _____
Does it cover athletically-related injuries? ___ Yes ___ No
Policy Limit: $ _____
Deductible: $ _____ Copay: $ _____

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. 16 ___ Yes 17 ___ No

AFFADAVIT: *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.*

STUDENT SIGNATURE: _____ **PARENT SIGNATURE:** _____ **DATE:** _____

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.*

STUDENT SIGNATURE: _____ **PARENT SIGNATURE:** _____ **DATE:** _____
Student (Parent/Guardian if under 18 years of age)

PLEASE INCLUDE A COPY OF BOTH SIDES OF YOUR INSURANCE CARD(S) WITH THIS FORM.

You should keep a copy of these documents for your records