

HEALTH INSURANCE INFORMATION SHEET

EVERY PARTICIPANT MUST HAVE THIS FORM ON FILE

Private insurance information must be provided, if applicable. Please be advised that, should a participant require medical attention, **you are responsible for paying any costs not covered by insurance.**

Participant Name _____

Participant's Address _____

Participant's Phone Number _____

Date of Birth _____

Insurance Company Name _____ Effective Date _____

Address of Insurance Company _____

Phone Number of Insurance Company _____ Group # _____

Policyholder's Name _____ Policy # _____

Policyholder's Address _____

Relationship to Participant _____

Contract # _____ Employee Number _____

I hereby authorize the release of any medical information which might be needed in connection with payment for medical services.

Parent/Guardian Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

I request that payment under my medical insurance program be made directly to the provider on any bills for services rendered by that provider. I understand that I am financially responsible for all costs not paid by my medical insurance program.

Parent/Guardian Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

EMERGENCY INFORMATION AND CONTACTS

Please complete this form in its entirety. This information will be helpful in the unlikely event of an accident or sudden illness.

Name of Personal Physician _____ Phone _____

Physician Address _____

Person(s) to be contacted in case of Emergency:

Name _____ Relationship _____

Address _____

Daytime Phone _____ Evening Phone _____ Cell Phone _____

Name _____ Relationship _____

Address _____

Daytime Phone _____ Evening Phone _____ Cell Phone _____