

GRINNELL COLLEGE



PARENT or Guardian/STUDENT INSURANCE INFORMATION FOR INTERCOLLEGIATE ATHLETICS

This form MUST be filled out for 2009-10 even if information is the same as previous years.

ATHLETE'S NAME _____
Date of Birth _____ Sport(s) _____
Permanent Address _____
STREET CITY, STATE, ZIP
School Address _____ School Phone _____

ATHLETE DRUG ALLERGIES/MEDICAL ALERTS _____

MOTHER'S NAME (or guardian) _____ Home Phone _____
Cell Phone _____
Home Address _____
STREET CITY, STATE, ZIP
Employer's Name _____ Work Phone _____

FATHER'S NAME (or guardian) _____ Home Phone _____
Cell Phone _____
Home Address _____
STREET CITY, STATE, ZIP
Employer's Name _____ Work Phone _____

**Please send a copy of the athlete's insurance card (front and back).
Please fill out one of the following two boxes.**

My dependent Son/Daughter **IS COVERED UNDER MY** insurance policy, as follows:
Insurance is in MOTHER'S / FATHER'S name. (CIRCLE ONE.)

Name of Group Insurance _____
Group Policy Number _____ ID Number _____
Mailing Address for Claims _____
STREET CITY, STATE, ZIP

Does this insurance require: Pre-Authorization for services? YES NO (Circle one)
A second opinion for surgery? YES NO (Circle one)

My dependent Son/Daughter **IS NOT COVERED UNDER MY** insurance policy.
He/She **DOES CARRY A PERSONAL POLICY** as follows

Name of Group Insurance _____
Group Policy Number _____ ID Number _____
Mailing Address for Claims _____
STREET CITY, STATE, ZIP

Does this insurance require: Pre-Authorization for services? YES NO (Circle one)
A second opinion for surgery? YES NO (Circle one)

I hereby certify that the answers provided are true, complete and correct to the best of my knowledge. I understand that I, my son/daughter must carry an insurance policy that will cover claims for injuries incurred while participating in intercollegiate athletic practices or games. I also understand that Grinnell College will not be responsible for payment of such claims. If there is a material change in coverage or expiration of coverage, I agree to notify Grinnell College of this development and update the insurance information I have on file with the Grinnell College Athletic Department.

DATE: _____ **SIGNATURE OF POLICY HOLDER** _____



Policy Holder Date of Birth: _____ Policy Holder Social Security No: _____ - _____ - _____
(When injuries are being treated, this information is requested by hospitals and medical offices. The information will not be used for any other purposes.)