

**Montana State University
Insurance Information Form
2009-2010**

Student-Athlete _____ Date of Birth _____

SSN _____ Sport _____

Academic Year(Circle One) Fr Soph Jr Sr 5th

Parent/Guardian Name(s) _____

Address _____

Home or Cell Phone (____) _____ Work Phone (____) _____

Insurance Information

Policy Holder Name _____ Date of Birth _____

Relationship to Student-Athlete _____

Address(if different) _____ Home Phone(if different) _____
_____ Work Phone(if different) _____

Insurance Company _____

Mailing Address for Claims _____

Group # _____ I.D. # _____

Policy # _____

Phone Number (____) _____

Effective Date of Policy _____ Expiration Date _____

Primary Physician _____

Office Number (____) _____

Policy Limit Amount \$ _____

Policy Deductible Amount \$ _____

Policy Co-Pay Amount \$ _____

Will the policy pay for medical treatment, hospital services, and other necessary services provided in the Bozeman, Montana area that arise due to an athletic injury? Yes _____ No _____

Has this been verified with your insurance carrier? Yes _____ No _____

(Please initial one of the following)

_____ I hereby authorize a claim to be filed on my behalf under the above group medical policy in the event an athletic injury is sustained by the previously named student-athlete.

_____ My son/daughter is NOT covered under my group medical policy and I understand they will need to obtain a policy that provides medical/health coverage.

I hereby certify that the answers provided are true, complete and correct to the best of my knowledge.

A photocopy of this authorization shall be considered as effective and valid as the original.

Date _____ Signature of Parent/Guardian _____