ALVIN COMMUNITY COLLEGE

FAMILY INSURANCE INFORMATION FORM

Note: Complete all blanks on this form. Failure to complete all blanks will result in claims processing delays.
This form must be signed and returned to Alvin Community College prior to participation in any sport.

Name of Athlete: _____ Sport: _____
Athlete Email: _____ Date of Birth:_____
Local Address: _____ Cell Phone: _____
Home Address _____ Home Phone: _____
City: _____ State:_____ Zip:_____ Parent(s) Email: _____

EMERGENCY CONTACT INFORMATION

1. Name: _____ Relationship to Athlete: _____ Work Phone:_____
   Email Address: _____ Cell Phone:_____ Home Phone:_____
2. Name: _____ Relationship to Athlete: _____ Work Phone:_____
   Email Address: _____ Cell Phone:_____ Home Phone:_____

PRIMARY MEDICAL INSURANCE

Please complete all information – incorrect information could result in claims processing delays.

Insurance Company:_____ Phone:_____
Insurance Company Address: _____
Policy #:_____ Group #:_____
Primary Physician Name: _____ Primary Physician Phone:_____
Name of Policyholder:_____ Relationship to Athlete:_____
Policyholder Date of Birth:_____ Policyholder SS#:_____

Is this plan an HMO or PPO? ☐ Yes ☐ No Is pre-authorization required to obtain treatment? ☐ Yes ☐ No

Is a second opinion required before surgery? ☐ Yes ☐ No

SECONDARY MEDICAL INSURANCE

If not applicable, please circle: NONE

Insurance Company:_____ Phone:_____
Insurance Company Address: _____
Policy #:_____ Group #:_____

I/We authorize Alvin Community College and their designated insurance company to inspect or secure copies of case history records, laboratory reports, diagnosis, x-rays, and any other data covering this and/or previous confinements and/or disabilities. A copy of this authorization shall be deemed as effective and valid as the original.
I/We agree that for expenses not covered by the Alvin Community College secondary insurance policy, I will assume responsibility for.

Policy Holder Signature:_____ Date: _____

Student-Athlete Signature: _____ Date:_____