

Medical Insurance Verification

(This side of form is required of ALL Eureka College Students)

Name: _____ **Date:** _____
Sport (if athlete): _____
Date of Birth: _____
Home Address: _____ Home Phone: (____) ____ - ____
City: _____ State: _____ Zip: _____

PARENT INFORMATION

(Required if student is covered under a parent's policy)

FATHER/GUARDIAN INFORMATION

Father's Name: _____
Address: _____

Employer: _____
Address: _____

Telephone: (____) ____ - ____

Medical Insurance
Company or Plan: _____
Address: _____

Policy Number: _____
Telephone: (____) ____ - ____

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

MOTHER/GUARDIAN INFORMATION

Mother's Name: _____
Address: _____

Employer: _____
Address: _____

Telephone: (____) ____ - ____

Medical Insurance
Company or Plan: _____
Address: _____

Policy Number: _____
Telephone: (____) ____ - ____

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

Student Information

(Required if student is covered under their own policy)

Medical Insurance Company or Plan:

(If you have no other insurance write "School Insurance Only")

Address: _____
City/State/Zip: _____

Policy Number: _____
Telephone: (____) _____

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

PLEASE COMPLETE AUTHORIZATION ON REVERSE SIDE OF THIS FORM

(This side of form is required to be completed by all ATHLETES at Eureka College)

AUTHORIZATION – To Permit Use and Disclosure of Health Information

This Authorization was prepared by First Agency, Inc. and Eureka College for purposes of obtaining information necessary to process a claim for benefits.

Upon presentation of the original or a photocopy of this signed Authorization, I authorize, without restriction (except psychotherapy notes), any licensed physician, medical professional, hospital or other medical-care institution, insurance support organization, pharmacy, governmental agency, insurance company, group policyholder, employer or benefit plan administrator to provide First Agency, Inc., Eureka College or any agent, attorney, consumer reporting agency or independent administrator, acting on its behalf, all information concerning advice, care or treatment provided the patient, employee or deceased named below, including all information relating to, mental illness, use of drugs or use of alcohol. This Authorization also includes information provided to our health division for underwriting or claim servicing and information provided to any affiliated insurance company on previous applications. If this Authorization is for someone other than myself, that individual has given me authority to act on his/her behalf as explained below.

I understand that I have the right to revoke this Authorization, in writing, at any time by sending written notification to Eureka College or to First Agency at 5071 West H Avenue, Kalamazoo, MI 49009-8501. I understand that a revocation will not be effective to the extent we have relied on the use or disclosure of the protected health information or if my Authorization was obtained as a condition to determine my eligibility for benefits. Revocation requests must be sent in writing to the attention of the Claims Supervisor.

I understand that First Agency, Inc. may condition payment of a claim upon my signing this authorization, if the disclosure of information is necessary to determine the level or validity of the claim payment. I also understand, once information is disclosed to us pursuant to this Authorization, the information will remain protected by First Agency, Inc. in accordance with federal or state law.

This Authorization is valid from the date signed for the duration of the claim

Name of Claimant (please print)

Signature of Claimant (if Claimant is 18 or older)

Date

Varsity Sport of Student: _____

In order to assist in paying for medical bills due to injury, Eureka College offers a SECONDARY insurance through First Agency of Kalamazoo, MI. An extra premium is paid by the athlete, which varies by sport, before being eligible for participation. Eureka College is not legally liable for injuries, and will not pay for medical bills due to injury or illness.

I, as an athlete, realize participation in athletics involves the potential for injury, which is inherent in all sports. I acknowledge that even with the best coaching, use of the most advanced protective equipment, and strict observance of the rules, injuries are still a possibility. On rare occasions, these injuries can be so severe as to result in total disability, paralysis, or death.

In case of injury, this person may be reached:

Name: _____

Relationship: _____

Phone #:(_____) _____ - _____

I hereby give authorization to the athletic trainer and team physicians to evaluate and treat any injuries that occur during athletic participation at Eureka College. I understand the team physicians and Head Athletic Trainer have the authority to eliminate me from further participation due an injury, illness, and/or any undue risk to the college.

Signature of Athlete: _____

Signature of Parent: _____

Randy Henkels, Head Athletic Trainer, Eureka College, 300 E College Avenue, Eureka, IL 61530