MEDICAL INSURANCE VERIFICATION

(This form is required of all Eureka College students)

Date: ______________________

Name: ______________________________________ Sport (if athlete): _________________________

Social Security Number: ______________________ Date of Birth: ____________________________

Eureka College, 300 E. College Avenue, Eureka, IL 61530 Athletic Dept. Phone: 309-467-6370

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: ______________________________

Social Security Number: ______________________

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: _____________________________

Social Security Number: _______________________

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

Is this plan an HMO or PPO? ☐ Yes ☐ No

PLEASE COMPLETE AUTHORIZATION ON REVERSE SIDE OF THIS FORM

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

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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 to 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