First Agency, Inc.
5071 West H Avenue
Kalamazoo, MI 49009-8501

PARENT/GUARDIAN/STUDENT INFORMATION FORM

RETURN FORM WHEN COMPLETE TO → Name of College/University EUREKA COLLEGE

Attention C.O. SHARKEY, HEAD ATHLETIC TRAINER

This form is to be completed by the Parents, Guardians or Student.

Address 300 EAST COLLEGE AVENUE

City EUREKA State IL Zip 61530

Note: Complete all blanks on this form. Failure to complete all blanks will result in claims processing delays.
If information is not applicable, indicate the reason it is not (e.g., deceased, divorced, unknown).

Name of Athlete _____ Sport _____

Social Security No. or Passport No. XXX-XX- Date of Birth _____

Please note that the Injured Person's Social Security Number MUST be provided as required by the Center for Medicare Services pursuant to Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007.

College Address 300 EAST COLLEGE AVE, EUREKA, IL 61530 College Phone ( ) _____

Home Address _____ Home Phone ( ) _____

City _____ State _____ Zip _____

FATHER/GUARDIAN INFORMATION

Father's Name _____

Social Security No. _____

Date of Birth _____

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 No. _____

Date of Birth

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

PLEASE COMPLETE AUTHORIZATION ON REVERSE SIDE OF THIS FORM

First Agency, Inc.
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AUTHORIZATION - To Permit Use and Disclosure of Health Information

This Authorization was prepared by First Agency, Inc. 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. or an 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 my agent or to us at the above address. 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.

I understand that I, or my authorized representative, is entitled to receive a copy of this authorization upon request

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

Name of Claimant (please print)

Name of Authorized Representative, or Next of Kin (please print)

Signature of Claimant (if claimant is 18 or older)

Date

Signature of Authorized Representative or Next of Kin

Date

Relationship of Authorized Representative or Next of Kin to Claimant