

## FORM B

### Insurance Information for Intercollegiate Athletes

1. Student's name \_\_\_\_\_

Parent's name \_\_\_\_\_ (Phone Number) \_\_\_\_\_

Street Address \_\_\_\_\_  
(Street) (City) (State) (Zip)

Card Holder's SS# \_\_\_\_\_ Card Holder's Date of Birth \_\_\_\_\_

2. Planned Sport(s) Participation \_\_\_\_\_

3. Does your son or daughter have any allergies? \_\_\_\_\_

4. Is your son or daughter covered at this time by your present surgical and hospital insurance policy?

\_\_\_ Yes \_\_\_ No

5. Is your insurance a group policy through your employer?

\_\_\_ Yes \_\_\_ No

If yes, name of your employer \_\_\_\_\_

6. Is your son or daughter covered at this time through affiliation with an HMO or PPO?

\_\_\_\_\_ Yes \_\_\_\_\_ No

7. Please give us the following information:

Name of Insurance Company \_\_\_\_\_

Insurance Company's Phone # \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

Certificate Number \_\_\_\_\_

Your insurance claims office location \_\_\_\_\_

Policy numbers \_\_\_\_\_

\_\_\_\_\_

Amount of Deductible \_\_\_\_\_

Please note that insurance provided by Bluffton University is limited to "usual and customary" charges.

\_\_\_\_\_ Date

\_\_\_\_\_ Parent or Guardian's Signature

**Note:** Please sign and return this copy along with a copy of parent or guardian's insurance card to:  
Bluffton University  
Athletic Department  
1 University Dr.  
Bluffton, OH 45817-2104