

DATE: _____

PARENT/ATHLETE INFORMATION FORM

MAIL TO:

Georgetown College Athletics
Attn: Randy McGuire, MS, ATC
400 E. College St.
Georgetown, KY 40324-1696

PARENT/GUARDIAN FAILURE TO COMPLETE ALL BLANKS WILL RESULT IN CLAIM PROCESSING DELAYS

NOTE: If information is not applicable, indicate reason (ex: deceased, divorced, unknown)

FRESH / SOPH / JUNIOR / SENIOR / 5TH YEAR SR (circle one)

I. PERSONAL INFORMATION:

Athlete Name _____
Social Security #: _____
College Box Number: _____
Home Address: _____
City: _____ State: _____

Sport(s) _____
Date of Birth: _____
College Phone: _____
Cell Phone: _____
Zip: _____

II. FATHER/GUARDIAN/HUSBAND INFORMATION

(circle one of the above)

Name: _____
SSN: _____
Address: _____

Phone: _____
Cell Phone: _____
E-mail: _____

MOTHER/GUARDIAN/WIFE INFORMATION

(circle one of the above)

Name: _____
SSN: _____
Address: _____

Phone: _____
Cell Phone: _____
E-mail: _____

III. EMPLOYMENT INFORMATION (DAYTIME EMERGENCY CONTACT)

Employer: _____
Address: _____
Phone: _____

Employer: _____
Address: _____
Phone: _____

IV. INSURANCE INFORMATION

Medical Insurance
Company/Plan: _____
Address: _____

Phone: _____
Group #: _____
Policy/ID #: _____
Coverage Ends When: _____

Medical Insurance
Company/Plan: _____
Address: _____

Phone: _____
Group #: _____
Policy/ID #: _____
Coverage Ends When: _____

- 1. Is the company/plan listed above considered:
 Health Maintenance Organization (HMO)
 Preferred Provider Organization (PPO)
 other: _____
 unknown

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 Health Maintenance Organization (HMO)
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 other: _____
 unknown

2. Is pre-authorization required to obtain treatment? Y N

Is pre-authorization required to obtain treatment? Y N

3. Does your insurance require a second opinion before surgery? Y N

Does your insurance require a second opinion before surgery? Y N

4. Does this insurance cover:
 Dental Eye

Does this insurance cover:
 Dental Eye

V. FAMILY DOCTOR INFORMATION

Primary Care Doctor: _____

Phone: _____

I hereby authorize Georgetown College and AIG Claims Services to inspect or secure copies of case history records, laboratory reports, diagnoses, x-rays, and any other data covering this and/or previous confinements and/or disabilities. A photocopy of this authorization shall be deemed as effective and valid as the original.

We authorize that Georgetown College or its insurance agent pay the medical vendors for any bills incurred from accidents that are covered under the policy purchased by Georgetown College.

Parent's Signature: _____

Athlete's Signature: _____

A PHOTOCOPY OF THE FRONT & BACK OF YOUR INSURANCE CARD IS HIGHLY RECOMMENDED!!!!!!!!!!