PARENT INFORMATION FORM

M-08/09

PARENTS/GUARDIAN TO COMPLETE AND RETURN TO:
FAX- (704) 406-3503
Attn: Jon Mitchell, Service Program Director

Gardner-Webb University
Athletic Training
P.O. Box 877
Boiling Springs, NC 28017

FAILURE TO COMPLETE ALL BLANKS WILL RESULT IN CLAIMS PROCESSING DELAYS. NOTE: Complete all blanks. If information is not applicable, indicate the reason it is not (e.g., deceased, divorced, unknown).

I. Name of Athlete: ______________________ Sport: ______________
Social Security #: ______________________ Date of Birth: ______________
GWU Campus Box: ______________________ Phone: ______________
Home Address: ______________________ Phone: ______________
City: ______________ State: ______________ Zip: ______________

II. Father/Guardian: ______________________ Mother/Guardian: ______________________
Social Security #: ______________________ Social Security #: ______________________
Date of Birth: ______________________ Date of Birth: ______________________
Address: ______________________ Address: ______________________
______________________ ______________________

III. Employer: ______________________ Employer: ______________________
Address: ______________________ Address: ______________________
______________________ ______________________
Telephone: ______________________ Telephone: ______________________

IV. Medical Insurance Company or Plan ______________________ Medical Insurance Company or Plan ______________________
Address: ______________________ Address: ______________________
______________________ ______________________

Policy Number: ______________________ Policy Number: ______________________

Policy Effective Dates: ______________________ Policy Effective Dates: ______________________

Policy Deductibles/Co-insurance: ______________________ Policy Deductibles/Co-insurance: ______________________

Phone Number: ______________________ Phone Number: ______________________

Is the company or plan listed above considered a Health Maintenance Organization (HMO) or a Preferred Provider Organization (PPO)? ☐ Yes ☐ No
If yes, please circle which type of Plan you have: HMO PPO

Is pre-authorization required to obtain treatment? ☐ Yes ☐ No
Does your insurance or plan require a second opinion before surgery? ☐ Yes ☐ No
Does your insurance or plan cover athletic injuries? ☐ Yes ☐ No
Does your insurance or plan provide out-of-state or out-of-network benefits? ☐ Yes ☐ No

I hereby authorize Gardner-Webb University 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 photostatic copy of this authorization shall be deemed as effective and valid as the original. We authorize that the university or its insurance agent pay the medical vendors direct for any bills incurred from accidents that are covered under the coverage purchased by the university.

Policy Holder's Signature: ______________________ Student's Signature: ______________________