

Ursinus College
Department of Athletics
INSURANCE INFORMATION REPORT

PLEASE ATTACH A COPY OF THE FRONT & BACK SIDES OF YOUR INSURANCE CARD

Athlete's Name _____ SS# _____ Date of Birth _____
Home Address _____ Home Phone _____
Athlete's Campus Address _____ Cell Phone _____
Sport (s) _____

Primary Insurance Coverage Information:

Name of Subscriber _____ Phone () _____ Relation _____
Address _____
Birth Date _____ Social Security # _____
Name of Employer _____
Address _____
Insurance Company _____ Group# _____
Address _____ ID # _____
Insurance Company Phone () _____

Do you need a referral from your primary physician to have diagnostic studies performed or to see another physician or specialist? (Yes or No) If yes, name and phone number of person to call for permission.

Secondary Insurance Coverage Information:

Name of Subscriber _____ Phone () _____ Relation _____
Address _____
Birth Date _____ Social Security # _____
Name of Employer _____
Address _____
Insurance Company _____ Group # _____
Address _____ ID # _____
Insurance Company Phone () _____

Do you need a referral from your primary physician to have diagnostic studies performed or to see another physician or specialist? (Yes or No) If yes, name and phone number of person to call for permission.

Please provide information on any other form of medical insurance that you may have that is not described above.
If none, please state.

RETURN TO: Athletic Department, Ursinus College, P.O. Box 1000, Collegeville, PA 19426