

INSURANCE INFORMATION

THE FOLLOWING INFORMATION AND AUTHORIZATION MUST BE FULLY COMPLETED, SIGNED AND RETURNED BEFORE YOUR CHILD IS ALLOWED TO PARTICIPATE AT CNU.

LAST NAME: _____ FIRST NAME: _____ MI: _____
SOCIAL SECURITY NUMBER: _____-_____-____ DOB: _____-_____-____ AGE: _____
SPORT: _____ CNU ID: _____
CELL PHONE #: _____ CNU PHONE #: _____

ADDRESS WHILE ATTENDING CNU

ROOM OR APT: _____
ZIP: _____
PRIMARY CARE PHYSICIAN (PCP): _____ PHONE: _____
ADDRESS OF PCP: _____

FATHERS NAME: _____ PHONE: _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____

MOTHERS NAME: _____ PHONE: _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____

IN CASE OF EMERGENCY, CONTACT (CIRCLE ALL THAT APPLY):
MOTHER FATHER GUARDIAN: _____

PLEASE CHECK ONE OF THE FOLLOWING:
____ THE STUDENT-ATHLETE IS PRIMARILY INSURED UNDER: _____
RELATION TO ATHLETE: _____ (PLEASE LIST THIS INFO BELOW)
____ MY CHILD HAS NO HEALTH INSURANCE

EMPLOYERS NAME: _____ PHONE: _____
EMPLOYERS ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____

INSURANCE COMPANY: _____ HMO PPO POS (circle one)
POLICY NUMBER: _____ GROUP NUMBER: _____
INSURANCE ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____
PHONE: _____

DOES YOUR INSURANCE REQUIRE:
SECOND OPINION FOR SURGERY: YES NO
PRE-AUTHORIZATION FOR SERVICES: YES NO

I AM FULLY AWARE THAT CNU HAS A \$1,000 DEDUCTIBLE FOR EVERY CLAIM THAT IS FILED. THIS MAY MEAN THAT I MIGHT HAVE TO PAY SOME OF MY CHILD'S BILLS, AFTER MY INSURANCE HAS PAID, IF CNU'S DEDUCTIBLE HAS NOT BEEN MET.

PARENTS SIGNATURE: _____ DATE: _____