



**2009-2010
Capital University
Health Insurance Information Form**

**Capital University
Athletic Training Department
1 College and Main
Columbus, OH 43209
Phone (614) 236-6622
Fax (614) 236-6178**

SECTION 1: EMERGENCY INFORMATION: PLEASE PRINT LEGIBLY

Last Name		First Name		MI
Permanent Address		SS#	Student ID#	
City, State, Zip		<input type="checkbox"/> Male <input type="checkbox"/> Female		Date of Birth mm/dd/yr
Emergency Contact Name:			Relationship:	
Home Phone ()		Work Phone ()		Cell Phone ()

SECTION 2: HEALTH INSURANCE INFORMATION

Policy Holder Name: _____ Relationship to Student: _____

Employer Name: _____ Occupation: _____

Employer Address: _____

SS# _____ Office Phone: () _____ Home Phone () _____

Insurance Company Name: _____

Address: _____

Plan / Policy Number(s): _____

Phone () _____ Is your insurance policy an HMO? YES NO

HMO Primary Care Physician: _____ Phone: () _____

By providing proof of health insurance, you are indicating:

- 1) Your coverage is comparable or better than the Capital University Student Health Insurance.
- 2) Your coverage will remain in effect throughout your entire sport season and cover athletically related injuries and illnesses.
- 3) If your insurance information changes, you will notify Athletic Training Services immediately.

**PLEASE PROVIDE A PHOTOCOPY OF BOTH THE FRONT AND BACK OF
YOUR INSURANCE CARD ONLY IN THE SPACES PROVIDED BELOW.
DO NOT ATTACH A SEPARATE COPY OF YOUR CARD TO THESE FORMS**

<p>FRONT OF INSURANCE CARD (Attach here only)</p>	<p>BACK OF INSURANCE CARD (Attach here only)</p>
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