# Montana State University
# Insurance Information Form
# 2008-2009

Student-Athlete ______________________________________________Date of Birth _______________

SSN___________________________ Sport ___________________________

Academic Year(Circle One) Fr Soph Jr Sr 5th

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Parent/Guardian Name(s)_________________________________________________________________
Address______________________________________________________________
______________________________________________________________

Home or Cell Phone (_____)_______________________ Work Phone (_____)_________________________

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**Insurance Information**

Policy Holder Name ____________________________________________________Date of Birth______________
Relationship to Student-Athlete____________________________________________
Address(if different)__________________________________ Home Phone(if different)________________________
_________________________________________ Work Phone(if different)_______________________

Insurance Company _______________________________________________________
Mailing Address for Claims ________________________________________________
________________________________________________

Group # ____________________________ I.D. # _____________________________
Policy #_____________________________
Phone Number (_____)_________________________
Effective Date of Policy ________________________ Expiration Date __________________________
Primary Physician ____________________________________
Office Number (_____)________________________________
Policy Limit Amount $________________________________
Policy Deductible Amount $_____________________________
Policy Co-Pay Amount $_______________________________

Will the policy pay for medical treatment, hospital services, and other necessary services provided in the Bozeman, Montana area that arise due to an athletic injury? Yes _______ No _______
Has this been verified with your insurance carrier? Yes _______ No_______
*(Please initial one of the following)*

______ I hereby authorize a claim to be filed on my behalf under the above group medical policy in the event an athletic injury is sustained by the previously named student-athlete.

______ My son/daughter is NOT covered under my group medical policy and I understand they will need to obtain a policy that provides medical/health coverage.

I hereby certify that the answers provided are true, complete and correct to the best of my knowledge.
A photocopy of this authorization shall be considered as effective and valid as the original.

Date __________________ Signature of Parent/Guardian__________________________________________