

PARENTS/GUARDIANS TO COMPLETE AND RETURN TO:

ATTN: ATHLETIC DEPARTMENT
MARIAN UNIVERSITY
3200 COLD SPRING ROAD
INDIANAPOLIS, IN 46222

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, i.e., deceased, divorced, unknown.

Name of Athlete: _____ Sport: _____

Social Security Number: _____ Date of Birth: _____

College Address: _____ Phone: (____) _____

Home Address: _____ Phone: (____) _____

City: _____ State: _____ Zip: _____

Father/Guardian: _____ Mother/Guardian: _____

Social Security Number: _____ Social Security Number: _____

Address: _____ Address: _____

Employer: _____ Employer: _____

Address: _____ Address: _____

Phone: (____) _____ Phone: (____) _____

Medical Insurance Co.: _____ Medical Insurance Co.: _____

Address: _____ Address: _____

Policy Number: _____ Policy Number: _____

Phone: (____) _____ Phone Number: (____) _____

Is the company or plan listed above considered a Health Maintenance Organization (HMO) or a Preferred Provider Organization (PPO)? Yes _____ No _____

Does your insurance or plan require a second opinion before surgery? Yes _____ No _____

I hereby authorize **Marian University** and Student Athletic Protection, Inc. of Kalamazoo, MI 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 photo static copy of this authorization shall be deemed as effective and valid as the original and valid up to two years from the date of signature.**

We authorize **Marian University** or its insurance agent to pay the medical vendors directly for any bills incurred from intercollegiate athletic accidents.

Student's Signature _____ **Date** _____

Parent's Signature _____