

Iowa State University
Student-Athlete Insurance Information Form

Student-Athlete Name: _____ Sport: _____
Social Security #: _____ Date of Birth: _____
Year in School: Fr Soph Jr Sr Scholarship: Yes No

Parent/Guardian Information:

Name(s): _____ Address: _____
City: _____ State: _____ Zip Code: _____
Home phone #: _____ Email Address: _____
Work phone # (s): _____
Cell phone # (s): _____
May we call you at work? Yes No On your cell phone? Yes No

- My son/daughter is NOT covered by any insurance policy.
 My son/daughter is covered under the insurance policy carried by:
 Father Mother Self More than one policy* Other _____
**If the student-athlete is covered under more than one policy, please list the primary information on the front and secondary on the back.

PLEASE INCLUDE COPIES (FRONT AND BACK) OF ALL INSURANCE CARDS.

Medical Insurance Information:

Policy Holder's Name: _____
SS#: _____ Date of Birth: _____ Home phone #: _____
Address: _____ City: _____ State: _____ Zip: _____
Employer: _____ Work phone #: _____
Insurance Company: _____ Effective Date: _____
Address: _____ City: _____ State: _____ Zip: _____
Insurance phone #: _____ Type of Insurance: PPO HMO Other
Policy #: _____ Group #: _____

Other Insurance Information:

Pharmacy Plan: _____ Pharmacy phone #: _____
Is there a separate Pharmacy card (from medical health insurance card)? Yes No
Dental Plan: _____ Dental phone #: _____
Is there a separate Dental card (from medical health insurance card)? Yes No
Do you anticipate any changes in coverage in the upcoming year? Yes No
If yes, please explain: _____

I acknowledge receiving a brochure explaining ISU's insurance policy. I understand the extent of the University's responsibility to scholarship or walk on student-athletes who become injured as a result of participation in an intercollegiate sports program. I authorize my insurance company to send payment directly to the provider. If I receive a payment for medical services, I will submit payment to the providers listed on the explanation of benefits from my insurance company. I authorize ISU Athletic Department to send insurance information to other medical providers when necessary.

Signature: _____ Date: _____
Parent/Guardian