

**MARIETTA COLLEGE ATHLETIC DEPARTMENT
INSURANCE FORM**

Name of Student _____ Soc. Sec. # _____
Sport(s) in which I will be participating _____ DOB _____
Home Address _____ City _____ State _____ Zip _____
MC Address _____

I **have** registered with the Marietta College Health and Accident Insurance program
 I **have not** registered with the Marietta College Health and Accident Insurance program
 I verify that I have checked with my health insurance company and my son/daughter is covered under my plan while attending Marietta College & network HMO or PPO doctors are available in the Marietta area. My child is currently insured under the following plan:

This form must be on file at the College before you can participate in any sport(s). The following questions must be answered in detail. This information is necessary in order to process insurance claims.

Father's Name _____ Soc. Sec# _____ DOB _____
Employed? Y _____ N _____ Employer _____
Address _____ Phone _____
Contact Person _____
Do you have group medical insurance coverage through your employer? Y _____ N _____
Insurance Company _____
Address _____ Policy # _____
Phone # _____

Mother's Name _____ Soc. Sec# _____ DOB _____
Employed? Y _____ N _____ Employer _____
Address _____ Phone _____
Contact Person _____
Do you have group medical insurance coverage through your employer? Y _____ N _____
Insurance Company _____
Address _____ Policy # _____
Phone # _____

Type of Plan (*check coverage if you have HMO, PPO, or Participating Provider Group*):
 Health Maintenance Organization (HMO) Standard Medical & Hospitalization Coverage
 Preferred Provider Organization (PPO) other (describe) _____

If you have medical insurance coverage, and your son/daughter is not covered or is partially covered due to policy limitations, please explain: _____

If your son/daughter has medical insurance coverage as an eligible dependent from your previous marriage, as mandated in a divorce decree, please give details for filing a claim: _____

I/WE AGREE THAT ALL INFORMATION PROVIDED IN THIS DOCUMENT IS ACCURATE & COMPLETE TO THE BEST OF MY/OUR KNOWLEDGE. I/WE UNDERSTAND THAT ANY INCORRECT OR UNDISCLOSED INFORMATION CAN RESULT IN DUPLICATE PAYMENTS CREATING A SUBSTANTIAL OVERPAYMENT. THE RESPONSIBILITY OF SUCH OVERPAYMENT WILL BE THE OBLIGATION OF THE UNDERSIGNED TO REIMBURSE IN FULL, UPON REQUEST, ALL AMOUNTS DEEMED REFUNDABLE.

Father/Guardian _____ Date _____
Mother/Guardian _____ Date _____

Please return **this form & copy of insurance card** to: Sam Crowther, Sports Medicine,
Marietta College, Marietta, OH 45750