



PARENTS INSURANCE INFORMATION

Athlete's Name: _____ Date of Birth: _____

Sport(s): _____ (Circle) Male Female Student Phone # _____

We, as the School, do not have the option of waiving the requirement of filing with your group insurance.

Please note: Most employers' group insurance allows dependent coverage to be continued to age 26 if the dependent is a full-time student. **DO NOT drop dependent coverage** while your son/daughter is participating in intercollegiate athletics.

THE FOLLOWING INFORMATION & AUTHORIZATION MUST BE FULLY COMPLETED, SIGNED, & RETURNED TO:

Walla Walla Community College
Attn: Wanda Williams, Athletics
500 Tausick Way
Walla Walla WA 99362

NOTE:
Please attach a copy of both the front and back
of your insurance card to this form.

Father's Name: _____ Date of Birth (if you are subscriber for insurance): _____

Home Address / City / State / Zip: _____

Home Phone: _____ Work Phone: _____

Employer's Name: _____

Name of Group Insurance Company: _____

Group Policy Number: _____ Subscriber ID # _____ Phone Number: _____

Mailing Address for Claims: _____

Is your dependent covered under the above policy? YES NO

Does your insurance require 1. Second opinion for surgery? YES NO

2. Pre-authorization for services? YES NO

Mother's Name: _____ Date of Birth (if you are subscriber for insurance): _____

Home Address / City / State / Zip: _____

Home Phone: _____ Work Phone: _____

Employer's Name: _____

Name of Group Insurance Company: _____

Group Policy Number: _____ Subscriber ID # _____ Phone Number: _____

Mailing Address for Claims: _____

Is your dependent covered under the above policy? YES NO

Does your insurance require: 1. Second opinion for surgery? YES NO

2. Pre-authorization for services? YES NO

Primary Care Provider (name and phone number) _____

_____ 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 my son/daughter named above.

_____ My son/daughter is **NOT** covered under my group insurance.

Signature of Parent: _____ **Date:** _____