

# Pennsylvania College of Technology

PENNSTATE



## Insurance Form

Wildcat Athletics Department  
Bush Campus Center, Rm. 166

**Failure to complete all blanks could result in claim processing delays.**

Name of student athlete \_\_\_\_\_  
Home address \_\_\_\_\_  
City \_\_\_\_\_  
Date of birth \_\_\_\_\_

Sport \_\_\_\_\_  
Student ID number \_\_\_\_\_  
Telephone (\_\_\_\_) \_\_\_\_\_  
State \_\_\_\_\_  
ZIP code \_\_\_\_\_

Father/Guardian \_\_\_\_\_  
Address \_\_\_\_\_  
Telephone (\_\_\_\_) \_\_\_\_\_

Mother/Guardian \_\_\_\_\_  
Address \_\_\_\_\_  
Telephone (\_\_\_\_) \_\_\_\_\_

Father's employer \_\_\_\_\_  
Address \_\_\_\_\_  
Telephone (\_\_\_\_) \_\_\_\_\_

Mother's employer \_\_\_\_\_  
Address \_\_\_\_\_  
Telephone (\_\_\_\_) \_\_\_\_\_

Basic medical/dental \_\_\_\_\_  
Address \_\_\_\_\_  
Telephone (\_\_\_\_) \_\_\_\_\_  
Group # \_\_\_\_\_  
Policy # \_\_\_\_\_

Major Medical \_\_\_\_\_  
Address \_\_\_\_\_  
Telephone (\_\_\_\_) \_\_\_\_\_  
Group # \_\_\_\_\_  
Policy # \_\_\_\_\_

A. Do you have medical insurance to cover this athlete? Yes \_\_\_\_\_ No \_\_\_\_\_

**If you answered no, you must complete the bottom of this form.**

B. Does your insurance plan provide major medical benefits? Yes \_\_\_\_\_ No \_\_\_\_\_

C. Does your insurance have a deductible? Yes \_\_\_\_\_ No \_\_\_\_\_ If so, how much? \_\_\_\_\_

D. Does your insurance plan provide dental benefits? Yes \_\_\_\_\_ No \_\_\_\_\_

E. Does your insurance require a second opinion before surgery? Yes \_\_\_\_\_ No \_\_\_\_\_

Is your insurance a Health Maintenance Organization (HMO) or Preferred Provider Organization (PPO)?  
Yes \_\_\_\_\_ No \_\_\_\_\_

Primary Care Physician \_\_\_\_\_  
Address \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

*We authorize Pennsylvania College of Technology or its authorized agents to pay the medical vendors directly for any bills incurred from accidents that are covered under the coverage purchased by Penn College. We understand that Penn College's Athletic Insurance is a secondary policy that covers a MAXIMUM of \$25,000 medical, \$15,000 life, and \$2,000 dental. Bills exceeding these amounts will be the responsibility of the student athlete.*

\_\_\_\_\_  
Parent's signature

\_\_\_\_\_  
Student athlete's signature

Send completed form to:  
Athletic Trainer, DIF #38, One College Avenue, Williamsport, PA 17701-5799;  
or bring with you to the athletic organizational meeting at the beginning of each semester.