

STUDENT INFORMATION

Personal Information

Student Name _____ Social Security # _____

Address _____ Phone # _____

Father Name _____ Mother Name _____

Address _____ Phone # _____

Father Employer Name & Address _____

Mother Employer Name & Address _____

Primary Physician Name _____ Phone # _____

Address _____

Insurance Information

Insurance Company Name _____

Address _____

Phone # _____

Policy Holder Name _____ ID # _____

I certify that the foregoing information is true and correct.

Student Signature _____ Date _____

Authorization to Release Information

I authorize any Health Care Provider, Insurance Company, Employer, Person or Organization to release information regarding medical, dental, mental, alcohol or drug abuse history, treatment or benefits payable, including disability or employment related information, to Summit America Insurance Services, L.C., the Plan Administrator, or their employees and authorized agents for the purpose of validating and determining benefits payable. A photocopy of this authorization shall be as valid as the original.

Signature _____ Date _____