STUDENT INFORMATION

Personal Information

Student Name_________________________S.S. #____________________Date of Birth_____________

____
Address   City   State   Zip   Phone #

Father Name____________________________Mother Name__________________________________

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Address   City   State   Zip   Phone #

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Father Employer   Address   State   Zip   Phone #

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Mother Employer   Address   State   Zip   Phone #

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Primary Physician   Address   State   Zip   Phone #

Insurance Information

Insurance Company Name____

____(____)_____________
Address   City   State   Zip   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______________________________