

DENTAL INSURANCE		INSURANCE COMPANY NAME:		PHONE NUMBER:	
POLICY NUMBER:			GROUP NUMBER:		PLAN NUMBER:
INSURANCE COMPANY MAILING ADDRESS:				DENTIST'S NAME:	
STREET		CITY		STATE	
				ZIP CODE	
				DENTIST'S PHONE #:	
PHARMACY INSURANCE <i>(IF DIFFERENT THAN PRIMARY INSURANCE)</i>		INSURANCE COMPANY NAME:		PHONE NUMBER:	
PATIENT ID OR POLICY #			GROUP NUMBER		CO-PAY AMOUNT?
POLICY HOLDER NAME		POLICY HOLDER SOCIAL SECURITY #		POLICY HOLDER D.O.B.	
<p>1. I certify that all of the above information is true and correct. If any incorrect or incomplete information has been given, I am responsible for all charges. _____ Initial</p> <p>2. I understand that I am responsible for payment of all charges incurred for claims classified as "non-athletic". _____ Initial</p> <p>3. If I change insurance companies or information changes during the year, I understand I must forward that information to the Athletic Medicine Department prior to any treatment received. _____ Initial</p> <p>4. I grant the insurance coordinator at Waldorf College, access to my medical records and insurance information in order to coordinate benefits, make inquiries and make payments on my behalf. This permission is granted for one year and may be revoked, in writing, at any time.</p> <p>Date: _____ Student Athlete Signature: _____</p>					
_____		_____		_____	
Policy Holder's Signature		Date		Student-Athlete Signature	
Date					
PLEASE ATTACH COPY OF INSURANCE CARD (BACK AND FRONT OF CARD) HERE.					

Please note: Sending a copy of your personal primary insurance cards and/or information to Nurse Mary, the Athletic Trainer, or anyone else at Waldorf College DOES NOT waive the student off of Waldorf's insurance plan. If you have questions on how to waive off Waldorf college's primary health insurance plan, please contact Bev Retland at 641.585.8144 or retlandb@waldorf.edu.