

**Jacksonville University Sports Medicine  
Athlete Personal / Dental Insurance Information 2011-2012**

**Student-Athlete Information**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Sport(s): \_\_\_\_\_  
Sex: \_\_\_\_\_ SS# \_\_\_\_\_ JU Student ID# \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Cell Phone # (\_\_\_\_) \_\_\_\_\_ Home Phone # (\_\_\_\_) \_\_\_\_\_ E-Mail: \_\_\_\_\_  
Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Allergies: NONE YES List: \_\_\_\_\_  
Medications Taken Regularly: NONE YES List: \_\_\_\_\_  
Medical Alerts/Conditions: NONE YES List: \_\_\_\_\_

**Dental Insurance Information**

Policy Holder's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SS# \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home #(\_\_\_\_) \_\_\_\_\_ Cell #(\_\_\_\_) \_\_\_\_\_ Work #(\_\_\_\_) \_\_\_\_\_ E-Mail: \_\_\_\_\_  
Policy Holders Employer: \_\_\_\_\_  
Insurance Company: \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Policy # \_\_\_\_\_ Group # \_\_\_\_\_ ID # \_\_\_\_\_

*PLEASE ATTACH AN **ENLARGED, CLEAN, COPY OF THE FRONT AND BACK** OF THE INSURANCE CARD BELOW*

FRONT

BACK

I certify that the above information is true and correct to the best of my knowledge. I understand that I must notify Jacksonville University in a timely manner if any changes in insurance should occur. I understand that failure to notify Jacksonville University of any insurance changes may result in Jacksonville University not being financially responsible for athletic related injuries.

\_\_\_\_\_  
Athlete Signature

\_\_\_\_\_  
Date