Jacksonville University Sports Medicine
Athlete Personal / Vision 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: _____

Vision 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