

# STUDENT INFORMATION

## Personal Information

Student Name \_\_\_\_\_ Social Security # \_\_\_\_\_

Address \_\_\_\_\_ Phone Number \_\_\_\_\_

Fathers Name \_\_\_\_\_ Mothers Name \_\_\_\_\_

Address \_\_\_\_\_

Phone Number \_\_\_\_\_

Fathers Employer Name \_\_\_\_\_

Mothers Employer Name \_\_\_\_\_

Primary Physician Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Address \_\_\_\_\_

## Insurance Information

Insurance Company Name \_\_\_\_\_

Address \_\_\_\_\_

Phone Number \_\_\_\_\_

Policy Holder Name \_\_\_\_\_ ID Number \_\_\_\_\_

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 \_\_\_\_\_