Clarkson University Athletic Department
Medical Insurance Information Form
10 Clarkson Ave., Box 5830, Potsdam, NY 13699
Phone: 315-268-2123 Fax:315-268-7613

Section 1: Student Athlete Information

Sport:_____ Last Name:_____ First Name:_____ MI:___

SSN:_ _ _-_ _-_ _ _ _ DOB:_ _/_ _/_ _ _ _ Student ID #_____ Class Year____

Home Phone #:_____ School Phone #:_____ Cell #:_____ Email:_____

Home Address_____ School Address_____

Section 2: Policy Holder Information

Last Name:_____ First Name:_____ MI:___

SSN:_ _ _ -_ _-_ _ _ _ DOB:_ _/_ _/_ _ _ _ Policy Holder's relation to the student athlete:
Self__ Parent/Guardian__ Spouse__ Other__

Home Phone #:_____ Work Phone #:_____ Cell #:_____ Email:_____

Home Address_____ Employer Address_____

Section 3: Primary Care Physician

Name:_____ Address:_____ Phone:_____

Section 4: Medical Policy Information

Insurance Co.:_____ Policy #:_____ Group #:_____ Plan #:_____

Member #:_____ Company Address:_____

Phone #:_____ Policy Type: HMO__ PPO__ PPOM__ Traditional__ Other__

Please Attach A Copy Of The Front And Back Of Medical Insurance Card Here

I understand that the information provided in this document will be used as the primary insurance in the event of an injury or illness related to participation in intercollegiate athletics at Clarkson University. I have received, read, understand and agree to the medical policies and procedures for the CU Sports Medicine Department as a condition of eligibility for CU athletic participation. I understand my responsibilities in the event I suffer an injury related to participation in varsity athletics.

_____ _____

Signature of Policy Holder Date Signature of Student Athlete Date