Gable Health and Counseling Center/Albright College Sports Medicine

Medical Insurance Information

Please complete the following information about the **student**.

Date:___/___/___

Name: _____

Anticipated Year of Graduation:_____

Social Security: _____

Age: _____

Date of Birth: _____

Home Address: _____

Phone #: _____

_____
City State Zip Code

Albright Campus Address: _____

Cell Phone #: _____

_____
City State Zip Code

Emergency Contact: _____

Phone #: _____

Primary Care Physician:_____

Phone #_____

Sport/s Participating In: _____

Please complete the following information about the **cardholder** (i.e. father/ mother) of your *Medical Insurance.* If you are not insured at this time, please write "not insured". ***Athletes are required to have medical coverage***

PRIMARY INSURANCE:

Card Holder Name: _____

Card Holder SS#: _____

Card Holder DOB: _____

Insurance Company Name:_____

Insurance Company Address: _____

_____

Insurance Company Phone #: _____

Group #: _____

Identification #: _____

Is student insured under this policy? _____

Is this Policy an HMO / PPO? YES NO

SECONDARY INSURANCE:

Card Holder Name: _____

Card Holder SS#: _____

Card Holder DOB: _____

Insurance Company Name: _____

Insurance Company Address: _____

_____

Insurance Company Phone #: _____

Group #: _____

Identification #: _____

Is student Insured under this policy? _____

Is this Policy an HMO / PPO? YES NO

Is a special laboratory needed for any blood work or cultures? (i.e. Labcorp, Quest, etc) If so, please specify the laboratory_____

It is important that we have this information on a yearly basis. Please provide a copy of your insurance card (front and back) with this form. Athletes must have this information on file prior to first athletic practice session.