Clemson University Athletic Department
PRESCRIPTION AND DENTAL COVERAGE

Student-Athlete Name _____ Date of Birth _____
Social Security #_____SPORT: _____

PRESCRIPTION COVERAGE:

Mailing address for paper claims:

_____	_____
(Insurance Company Name)	(Rx Group #)
_____	_____
(Address)	(RxBin #)
_____	_____
(City, State, Zip)	(Subscriber/ Parent Name)
_____	_____
(Phone Number)	(Subscriber Date of Birth)

DENTAL COVERAGE:

Mailing address for paper claims:

_____	_____
(Insurance Company Name)	(Member ID/ Policy #)
_____	_____
(Address)	(Group #)
_____	_____
(City, State, Zip)	(Subscriber/ Parent Name)
_____	_____
(Phone Number)	(Subscriber Date of Birth)

PLEASE BE SURE TO ATTACH COPIES (FRONT & BACK) OF ALL APPLICABLE INSURANCE CARDS

Mail completed form to: **Clemson University Athletic Department, P.O. Box 31, Clemson, SC 29633**

Updated 5-5-10