



Clemson University Athletic Department
HEALTH INSURANCE INFORMATION

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

Primary Insurance

INSURANCE COMPANY NAME	TYPE OF PLAN (Circle one)	
	<i>PPO HMO POS Medicaid OTHER</i>	
CLAIMS ADDRESS	Primary care Physician name and phone #	
POLICY/ MEMBER ID NUMBER	INSURANCE COMPANY PHONE #	
	()	
GROUP NUMBER	POLICYHOLDER (Parent Name)	
EFFECTIVE DATE	POLICYHOLDER DATE OR BIRTH (required)	
DOES YOUR INSURANCE PROVIDER REIMBURSE YOU DIRECTLY, RATHER THAN THE MEDICAL PROVIDER please circle one	YES	NO

Secondary Insurance (if applicable)

INSURANCE COMPANY NAME	TYPE OF PLAN (Circle one)	
	<i>PPO HMO POS Medicaid OTHER</i>	
CLAIMS ADDRESS	Primary care Physician name and phone #	
POLICY/ MEMBER ID NUMBER	INSURANCE COMPANY PHONE #	
	()	
GROUP NUMBER	POLICYHOLDER (Parent Name)	
EFFECTIVE DATE	POLICYHOLDER DATE OF BIRTH (required)	

**SEE SEPARATE DENTAL / PRESCRIPTION FORM **

PLEASE BE SURE TO ATTACH BOTH COPIES (FRONT & BACK) OF CURRENT INSURANCE CARDS