



The College of New Jersey

STUDENT NAME _____ SPORT _____

SOCIAL SECURITY NUMBER _____ DATE OF BIRTH _____

STATEMENT OF HEALTH INSURANCE COVERAGE UNDER PARENT OR GUARDIAN

THIS FORM MUST BE FILLED OUT COMPLETELY BEFORE CLAIMS CAN BE PROCESSED

Father/Guardian _____ Mother/Guardian _____

Address _____ Address _____

Phone # _____ Phone # _____

SS# _____ SS# _____

Employer _____ Employer _____

Address _____ Address _____

Phone # _____ Phone # _____

INSURANCE COMPANY _____ INSURANCE COMPANY _____

Address _____ Address _____

Customer Service # _____ Customer Service # _____

Father/Guardian's Policy (ID) # _____ Mother/Guardian's Policy (ID) # _____

Student-athlete's Policy # _____ Student-athlete's Policy # _____

Group # _____ Group # _____

Plan Type _____ Plan Type _____

IS A REFERRAL NECESSARY? Yes ___ No ___ IS A REFERRAL NECESSARY? Yes ___ No ___

IF "YES" PLEASE COMPLETE: PRIMARY CARE PHYSICIAN NAME _____

PHONE # _____

MEDICAL INFORMATION AUTHORIZATION/ASSIGNMENT OF BENEFITS

You are hereby authorized to furnish at the request of this institution or their representatives, information which you may possess, including findings and treatment rendered, X-rays and copies of all hospital or medical records: all occasioned by professional services and hospital care rendered on my behalf.

The foregoing authorization is granted with the understanding that any legal rights I may ordinarily have to claim communications between us as privileged are hereby expressly and voluntarily waived. A Photostat of this authorization shall be considered as effective and valid as the original.

Claimant or Authorized Person's Signature

Date