

Purdue University North Central Emergency Medical Form

This information is required each year to aid the Athletics Department and trainers in complying with the changing requirements of health insurance policies. Failure to fill in all blanks will result in claims processing delays. All students should complete and return this form as soon as possible, and before registration for the fall term, to:

**Purdue University North Central
Attn: Athletics Department
1401 South U.S. 421
Westville, IN 46391**

A. PERSONAL INFORMATION

DATE: _____

Student's Name: _____ Birth Date: _____ Sport: _____
School Year: _____ Red Shirt _____ FR _____ SOPH _____ JR _____ SR _____ 5th Year
Home Address: _____ Home Phone: _____
City/State: _____ Zip Code: _____ Social Security #: _____
E-mail: _____ Cell Phone: _____ Pager: _____
College Address: _____ College Phone: _____
Emergency Contact: _____ Emergency Contact Phone: _____

B. INSURANCE *Please attach a copy of your insurance card(s) if possible.***

Do you have Health Insurance? YES _____ NO _____ (If YES, please fill out the rest of this form. If NO, please skip to section C).
Primary Health Insurance: _____ Father/Guardian _____ Mother/Guardian
Father/Guardian: _____ Mother/Guardian: _____
Address: _____ Address: _____
Phone (if different from above) _____ Phone (if different than above) _____
Cell Phone: _____ Pager: _____ Cell Phone: _____ Pager: _____
E-Mail: _____ E-Mail: _____
Birth Date: _____ Social Security #: _____ Birth Date: _____ Social Security #: _____
Employer: _____ Employer: _____
Address: _____ Address: _____
Work Phone: _____ Work Phone: _____
Company or Plan Covering Student: _____ Company or Plan Covering Student: _____
Address: _____ Address: _____
Insurance Co. Phone: _____ Insurance Co. Phone: _____
Insurance Plan: _____ Insurance Plan: _____
Insurance Policy #: _____ Insurance Policy #: _____
Employee ID: _____ Employee ID: _____
HMO _____ PPO _____ POS _____ Other _____ HMO _____ PPO _____ POS _____ Other _____
Does this plan require a second opinion before surgery? YES NO YES NO
Name of family physician: _____
Address: _____ Phone: _____

I hereby authorize Purdue University North Central and K&K Insurance of Fort Wayne, Indiana, to inspect or secure copies of case history records, laboratory reports, diagnoses, x-rays, and other data covering this and/or previous confinements and/or disabilities. A photo static copy of this authorization shall be deemed as effective and valid as the original for up to two years from the date of signature.

We authorize Purdue University North Central or its insurance agent to pay the medical vendors directly for any bills incurred from intercollegiate athletic accidents. We also understand that K&K Insurance is a secondary insurance and will only pay after ALL deductibles have been met and ALL bills processed through the student athlete's primary insurance(s).

Signature of Parent/Guardian: _____ Date: _____
Signature of Student: _____ Date: _____