

**MEDICAL INSURANCE INFORMATION FORM**

Participant Name: _____		
Last	First	Middle I.
Address: _____		
Street	Apt. #	
City	State	Zip Code
Age: _____		Date of Birth: _____
Parent/Guardian Name(s): _____		
Business phone:	mother: _____	step mother: _____
	father: _____	step father: _____
Home phone:	mother: _____	step mother: _____
	father: _____	step father: _____
Neighbor or Relative (Other than parent/guardian): Phone: _____		

**PRIMARY INSURANCE INFORMATION**

<b>PARENT'S INSURANCE COVERING PARTICIPANT</b>	
Insured: _____	Date of Birth: _____
Policy No.: _____	Member ID #: _____
Insurance Co.: _____	Phone #: _____
Insurance Co. Address.: _____	

<b>SECOND PARENT'S INSURANCE (if participant is also covered under this policy)</b>	
Insured: _____	Date of Birth: _____
Policy No.: _____	Member ID #: _____
Insurance Co.: _____	Phone #: _____
Insurance Co. Address.: _____	

**✓ Check and sign if participant has no health coverage.**

There is no health insurance coverage for this participant at this time.	
Signature Parent/Guardian.: _____	Date: _____

**You MUST submit a copy of the front and back of all insurance and Rx identification cards covering participants.**