

# INSURANCE INFORMATION SHEET FOR FAU MARCHING OWLS

(To be used when filing medical claims)

Student's Name: \_\_\_\_\_ Section: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_

Parent(s)/Guardian(s) Name: \_\_\_\_\_

Parent(s)/Guardian(s) Address: \_\_\_\_\_  
(Street Address)

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Parent(s)/Guardian(s) Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

## PLEASE COMPLETE ONE OF THE TWO SECTIONS BELOW (WHICHEVER IS APPLICABLE TO YOU)

### MY HEALTH INSURANCE IS PROVIDED THROUGH...

#### (A) PARENT(S)/GUARDIAN(S) EMPLOYER

Insured's Name: \_\_\_\_\_  
(Parent/Guardian)

Insured's SS#: \_\_\_\_\_

Employer: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State/Zip: \_\_\_\_\_

Group Policy #: \_\_\_\_\_

Or ID or Certificate #: \_\_\_\_\_

\*Insurance Co: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State/Zip: \_\_\_\_\_

Ins. Co. Phone #: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

#### (B) MY OWN PRIVATE PLAN

Insurance Co.: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_

Zip: \_\_\_\_\_

Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

\*Policy #: \_\_\_\_\_

Any other ID: \_\_\_\_\_

\*IMPORTANT – Please indicate below if you have a HMO plan with Primary Physician requirements. In other words, before seeing another doctor for treatment and/or surgery, does prior approval have to be obtained from your primary physician? (Circle) YES NO

I certify that, to the best of my knowledge, the information stated above is accurate. I acknowledge that failure to provide accurate health insurance information may result in dismissal from the FAU Marching Owls. I certify that the policy listed above is current and that I am covered under said policy. I agree to report changes in my health insurance coverage that may occur during my active participation to the FAU Department of Music Office.

Signature of Student: \_\_\_\_\_ Date: \_\_\_\_\_