COLDWATER
foundation

PARTICIPANT INSURANCE FORM

PARENT/GUARDIAN: PLEASE STAPLE A COPY OF **BOTH SIDES** OF YOUR MEDICAL INSURANCE CARD TO THIS SHEET AND RETURN TO COLDWATER FOUNDATION.

A copy of your Medical Insurance Card must be attached because it will be presented to the Hospital at the time of service. If the information is not attached, the parent/legal guardian will be billed as private pay and will be responsible for the bill. Your cooperation is greatly appreciated. Thank You.

STUDENT'S NAME:_____SS #_____BIRTH DATE:_____

Coldwater requires that all students have their own health and accident insurance. Please complete this form so that we will have information concerning your insurance coverage. It is your responsibility to make sure your insurance will cover you for the duration of the course. The student will be responsible for obtaining any necessary pre-admission review.

ALL STUDENTS MUST PROVIDE PROOF OF HEALTH COVERAGE TO PARTICIPATE.

If you do not already belong to a regular health program, we suggest a short-term policy that you may buy from your local insurance agent.

NAME AND ADDRESS OF PERSON UNDER WHOSE NAME THE POLICY IS CARRIED:

Name: _____ Address: _____

_____

DAY PHONE: (____)_____ NIGHT PHONE: (____)_____

Email:_____

NAME OF INSURANCE COMPANY:_____

POLICY #_____GROUP #_____AGREEMENT #

_____

ADDRESS WHERE CLAIMS MUST BE SUBMITTED:

_____

_____

IF GROUP INSURANCE, GIVE NAME OF GROUP: (employer, union or association through which the

student is insured)

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