

HEALTH INSURANCE INFORMATION FORM

WASHINGTON COLLEGE
HEALTH SERVICES
Queen Anne's House
Washington Avenue
Chestertown, MD 21620



STUDENT NAME (LAST, FIRST M.I.)			NEW / RETURNING?
SOCIAL SECURITY NUMBER	DATE OF BIRTH	PHONE NUMBER	MOBILE PHONE NUMBER
<input type="checkbox"/> YES, I WOULD LIKE TO PURCHASE THE HEALTH INSURANCE OFFERED BY WASHINGTON COLLEGE. I UNDERSTAND THAT MY ACCOUNT WILL BE CHARGED FOR THE PREMIUM AMOUNT.			
<input type="checkbox"/> NO, I WOULD NOT LIKE TO PURCHASE THE HEALTH INSURANCE OFFERED BY WASHINGTON COLLEGE. INSURANCE INFORMATION MUST BE PROVIDED BELOW.			

FATHER'S NAME (LAST, FIRST M.I.)		MOTHER'S NAME (LAST, FIRST M.I.)	
DATE OF BIRTH		DATE OF BIRTH	
HOME ADDRESS, CITY, STATE, ZIP		HOME ADDRESS, CITY, STATE, ZIP	
HOME PHONE	MOBILE PHONE	HOME PHONE	MOBILE PHONE
EMPLOYER	WORK PHONE	EMPLOYER	WORK PHONE
EMPLOYER ADDRESS, CITY, STATE, ZIP		EMPLOYER ADDRESS, CITY, STATE, ZIP	
NAME OF INSURANCE PROVIDER		POLICY HOLDER'S NAME	
INSURANCE COMPANY ADDRESS, CITY, STATE, ZIP		POLICY NUMBER	GROUP NUMBER
INSURANCE AUTHORIZATION PHONE NUMBER		IS YOUR INSURANCE A HEALTH MAINTENANCE ORGANIZATION (HMO)?	
DOES YOUR INSURANCE REQUIRE USE OF A PARTICIPATING PHYSICIAN OR HEALTH CARE FACILITY?	IS PRE-AUTHORIZATION REQUIRED FOR SURGERY?	PRESCRIPTION COVERAGE? CO-PAY?	
NAME OF PRESCRIPTION DRUG PLAN		POLICY NUMBER	

PLEASE ENCLOSE A COPY OF BOTH FRONT AND BACK OF YOUR INSURANCE CARD AND PRESCRIPTION DRUG CARD (if separate card).

I HEREBY CERTIFY THAT THE ANSWERS PROVIDED ARE TRUE, COMPLETE, AND CORRECT TO THE BEST OF MY KNOWLEDGE.

SIGNATURE OF STUDENT

DATE

FORM MUST BE COMPLETED & RETURNED TO HEALTH SERVICES BY DUE DATE, TO AVOID A NON-REFUNDABLE INSURANCE CHARGE.