UNIVERSITY OF KENTUCKY **Camps, Conferences & Field Trips**

MEDICAL INSURANCE INFORMATION FORM

Participant Name:_____
Last First Middle I.

Address:_____
Street Apt. #

_____
City State Zip Code

Participant's Social Security No.:_____

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

PARENT'S INSURANCE COVERING PARTICIPANT

Insured:_____ Date of Birth:_____

Policy No.:_____ Member ID #.:_____

Insurance Co.:_____ Phone #:_____

Insurance Co. Address.:_____

SECOND PARENT'S INSURANCE (if participant is also covered under this policy)

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.

CLEAR PAGE