

Please complete both copies of this form.

Howard Community College, Department of Athletics
Student Athlete Insurance Form

Athlete Name: _____
(PRINT)

Address: _____ City: _____ State: ____ Zip: _____

Home phone: (____) _____ Work/Cell phone: (____) _____

EMERGENCY CONTACT: _____ Relationship: _____

Home phone :(____) _____ Work/Cell :(____) _____

INSURANCE INFORMATION

Name of Plan: _____ Policy Number: _____

Group Number: _____ Type of Insurance: HMO PPO POS

Other: _____

I have no medical insurance: _____

Allergies: _____

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