

First Agency, Inc.
5071 West H Avenue
Kalamazoo, MI 49009-8501

PARENT / GUARDIAN / STUDENT INFORMATION FORM

RETURN FORM WHEN COMPLETE TO:

Name of College/University KIRKWOOD COMMUNITY COLLEGE
Attention RUTH MAIN SOENKSEN
Address PO BOX 2068
City CEDAR RAPIDS State IA Zip 52406

This form is to be completed by the
Parents, Guardians, or Student

Note: Complete all blanks on this form. Failure to complete all blanks will result in claims processing delays.

If information is not applicable, indicate the reason it is not (e.g., deceased, divorced, unknown).

Name of Athlete _____ Sport _____
Social Security # or Passport # _____ Date of Birth _____
College Address _____ College Phone () _____
Home Address _____ Home Phone () _____
City _____ State _____ Zip _____

FATHER/GUARDIAN INFORMATION

MOTHER/GUARDIAN INFORMATION

| | |
|---|---|
| Father's Name _____ | Mother's Name _____ |
| Social Security # _____ | Social Security # _____ |
| Address _____ | Address _____ |
| Employer _____ | Employer _____ |
| Address _____ | Address _____ |
| Telephone () _____ | Telephone () _____ |
| Medical Insurance Company or Plan _____ | Medical Insurance Company or Plan _____ |
| Address _____ | Address _____ |
| Policy # _____ | Policy # _____ |
| Telephone () _____ | Telephone () _____ |

Is this plan an HMO or PPO? Yes No

Is pre-authorization required to obtain treatment? Yes No

Is a second opinion required before surgery? Yes No

Is this plan an HMO or PPO? Yes No

Is pre-authorization required to obtain treatment? Yes No

Is a second opinion required before surgery? Yes No

PLEASE COMPLETE AUTHORIZATION ON REVERSE SIDE OF THIS FORM

First Agency, Inc.
5071 West H Avenue
Kalamazoo MI 49009-8501

AUTHORIZATION - To Permit Use and Disclosure of Health Information

This Authorization was prepared by First Agency, Inc. for purposes of obtaining information necessary to process a claim for benefits.

Upon presentation of the original or photocopy of this signed Authorization, I authorize, without restriction (except psychotherapy notes), any licensed physician, medical professional, hospital or other medical-care institution, insurance support organization, pharmacy, governmental agency, insurance company, group policyholder, employer or benefit plan administrator to provide First Agency, Inc. or an agent, attorney, consumer reporting agency or independent administrator, acting on its behalf, all information concerning advice, care or treatment provided the patient, employee or deceased named below, including all information relating to, mental illness, use of drugs or use of alcohol. This Authorization also includes information provided to our health division for underwriting or claim servicing and information provided to any affiliated insurance company on previous applications. If this Authorization is for someone other than myself, that individual has given me authority to act on his/her behalf as explained below.

I understand that I have the right to revoke this Authorization, in writing, at any time by sending written notification to my agent or to us at the above address. I understand that a revocation will not be effective to the extent we have relied on the use or disclosure of the protected health information or if my Authorization was obtained as a condition to determine my eligibility for benefits. Revocation requests must be in writing to the attention of the Claims Supervisor.

I understand that First Agency, Inc. may condition payment upon my signing this authorization, if the disclosure of information is necessary to determine the level or validity of the claim payment. I also understand, once information is disclosed to us pursuant to this Authorization, the information will remain protected by First Agency, Inc. in accordance with federal or state law.

This Authorization is valid from the date signed for the duration of the claim

Name of Claimant (please print)

Name of Authorized Representative, or Next of Kin (please print)

Signature of Claimant (if claimant is 18 or older)

Date

Signature of Authorized Representative or Next of Kin

Date

Relationship of Authorized Representative or Next of Kin to Claimant