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

PARENT / GUARDIAN / STUDENT INFORMATION FORM

RETURN FORM WHEN COMPLETE TO:

KIRKWOOD COMMUNITY COLLEGE
ATTENTION: ATHLETIC DIRECTOR / JOHNSON HALL
6301 KIRKWOOD BLVD SW
CEDAR RAPIDS, IA 52404

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 ____________________
Date of Birth ____________________	Date of Birth ____________________
Social Security # ____________________	Social Security # ____________________
____ Parent deceased	____ Parent deceased
____ No contact with parent	____ No contact with parent
____ Other, please indicate ____________________	____ Other, please indicate ____________________
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 this plan an HMO or PPO? ☐ Yes ☐ No
Is pre-authorization required to obtain treatment? ☐ Yes ☐ No	Is pre-authorization required to obtain treatment? ☐ Yes ☐ No
Is a second opinion required before surgery? ☐ Yes ☐ No	Is a second opinion required before surgery? ☐ Yes ☐ No

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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