

Ascension Benefits & Insurance Solutions PO BOX 25936 Overland Park, KS 66225 1-877-246-6997

	PLEASE CO	OMPLETE IN FULL TO		IM FORI ER PROCESSING -		FILING INSTRUCTIONS.		
				D BY PARENT				
NAME OF PATIENT	(Last Name)	(First Name	÷)	(Middle Initial)	STUDENT ID NU	JMBER		
ADDRESS (Street)		(City)			(State)	(Zi	ip)	
PHONE NUMBER			DATE OF BIRTH					
DATE & TIME ACCIDENT C	OR II I NESS REGAN					MALE FEMALE WAS ACCIDENT DUE TO EMPLOYMENT?		
ATE & TIME ACCIDENT	ONTELNESS BEGAN					WAS ACCIDENT DOE TO EMILEOTMENT:	YES 🗖	NO □
IATURE OF INJURY OR IL	LLNESS				HAVE YOU EVER	BEEN TREATED FOR THIS CONDITION BEFO		
ACCIDENT DI FACE CT	ATE LIQUE WILLEN AND WILLIAM	A CCUDENT OCCUPATO					YES 🗖	NO 🗆
ACCIDENT, PLEASE STA	ATE HOW, WHEN, AND WHERE A	ACCIDENT OCCURRED:						
INJURY RELATED TO PA	ARTICIPATION IN INTERCOLLEG	SIATE SPORTS? YES	NO 🗆	ı				
O YOU HAVE ANY OTHE	ER INSURANCE, INCLUDING BU	T NOT LIMITED TO GROUP	OR INDIVIDUAL HEA	ALTH AND/OR ACCIDE	NT, GOVERNMENT P	PLAN, OR AUTOMOBILE PLAN? YES) NO	
YES, PLEASE GIVE NAM	ME, ADDRESS, PHONE NUMBER,	, AND POLICY NUMBER OF	THIS PLAN					
UBSCRIBERS NAME:				EEEECTIVE DAT				
	3, PLEASE PROVIDE PARENT/GU	JARDIAN'S INFORMATION B	BELOW:	LITECTIVEDATI	<u></u>			
IAME OF PARENT/GUARI			(First Name)	(Mid	ddle Initial)			
		(City)			(State)	(Zi	ip)	
			DIZATIONITO	N DEL EACE IN			ip)	
DDRESS (Street)		AUTHO) RELEASE IN	FORMATION	l		
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DDRESS (Street) authorize any Hea	ment or benefits payabl	AUTHOI ance Company, Emplo e, including disability	oyer, Person or 0 7 or employmen	Organization to r at related informa	FORMATION elease informat tion, to Summit	ion regarding medical, dental, me	ntal, alcohol c	ator, c
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