VIRGINIA MILITARY INSTITUTE

CADET HEALTH INSURANCE INFORMATION

PLEASE INCLUDE A CLEAR COPY OF BOTH SIDES OF INSURANCE CARD WITH THIS FORM

FOR NCAA ATHLETES

ONLY

Sport: _____

CADET INFO

Cadet's Name: _____

Cadet's Date of Birth: _____

Cadet's Cell Phone: _____

☐ CHECK HERE IF YOU DO NOT HAVE HEALTH INSURANCE. THEN PROCEED TO PAGE 2.

POLICYHOLDER INFO

Policyholder's Name: _____ Policyholder's DOB: _____

Policyholder's Street Address: _____

City: _____ State: _____ Zip Code _____

Policyholder's Phone: Cell: _____

Home: _____ Work: _____

Policyholder's Employer: _____

INSURANCE INFORMATION

Insurance Company Name: _____

Insurance Company's Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Insurance Company's Phone Number: _____

Insured's Policy/ID Number: _____ Group Number or Name: _____

Do you need a referral from your PCP for x-ray or off post appointment? _____ Yes _____ No

If yes, what is the PCP's name? _____ PCP's Phone Number _____

***Cadets / Parents/ Guardians are responsible for obtaining referrals from PCPs ***

Do you have prescription coverage? _____ Yes _____ No

If yes, please provide a copy of medical/prescription information including co-payment amount.

PARENT/GUARDIAN CONTACT INFO

Parent/Guardian	Parent/Guardian
Name:_____	Name: _____
Address:_____	Address: _____
City:_____	City: _____
State:_____ ZIP:_____	State:_____ ZIP: _____
Home Phone:_____	Home Phone: _____
Work Phone:_____	Work Phone: _____
Cell Phone:_____	Cell Phone: _____

EMERGENCY

If parent(s) or guardian(s) listed above cannot be contacted, please notify the following:

Name:_____ Relationship:_____

Address:_____

Phone Number: _____

MILITARY INFO

Military Dependents:

Military Dependent covered by Tricare_____ Yes_____ No

Please check which coverage:_____ Tricare Select_____ Tricare Prime

PLEASE ALSO INCLUDE A COPY OF THE APPLICANT'S MILITARY ID CARD

Because of recurrent problems with PCM assignment/referrals for off post care for cadets while here at VMI, we urge switching your cadet to **TRICARE SELECT instead of TRICARE PRIME**. Details are available from your local Tricare Service Center or you may want to visit the TRICARE website http://www.mytricare.com

CONSENT

I give consent for my cadet to receive treatment at the VMI Infirmary and for any other treatment or testing needed off post. ***I will notify the VMI Infirmary immediately of any changes in my cadet's insurance coverage via*** **http://vmi.medicatconnect.com .**

Signature of Parent/Guardian **(Required if cadet is under 18)**: _____

Printed Name of Parent/Guardian: _____ Date: _____

NCAA ATHLETES ONLY

For NCAA Athletes Only

- I have read and understand VMI's Athletic Insurance policy which is available online at **www.vmi.edu**. To view policy, click on the following tabs: Athletics (homepage) > Inside Athletics > Sports Medicine.
- I will comply with all medical insurance policies and procedures and I agree to the terms of the coverage. Following any medical services, I understand that I have 30 days to send bills and explanations of benefits to VMI Sports Medicine or I may become financially responsible.
- I will notify VMI Sports Medicine immediately upon any change in my cadet's health insurance coverage.

Date:_____ Signature of Parent or Guardian: _____

Printed Name of Parent or Guardian _____