

**INSURANCE INFORMATION SHEET FOR SOUND OF THE SOUTH MEMBERS**

(To be used when filing medical claims)

Student's Name: \_\_\_\_\_ Section: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_

Parent(s)/Guardian(s) Name:

\_\_\_\_\_

Parent(s)/Guardian(s) Address:

\_\_\_\_\_

(Street Address)

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Parent(s)/Guardian(s) Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**PLEASE COMPLETE ONE OF THE TWO SECTIONS BELOW  
(WHICHEVER IS APPLICABLE TO YOU)**

**(A) PARENT(S)/GUARDIAN(S) EMPLOYER**

Insured's Name:

\_\_\_\_\_

(Parent/Guardian)

Employer:

\_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State/Zip: \_\_\_\_\_

Group Policy #: \_\_\_\_\_

Or ID or Certificate#: \_\_\_\_\_

Insurance Co.: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State/Zip: \_\_\_\_\_

Ins. Co. Phone # (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**B) MY OWN PRIVATE PLAN**

Insurance Co.: \_\_\_\_\_

\_\_\_\_\_

Address:

\_\_\_\_\_

City: \_\_\_\_\_ State/Zip: \_\_\_\_\_

Phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

\*Policy #: \_\_\_\_\_

Any other ID:

\_\_\_\_\_

**\*IMPORTANT – Please indicate below if you have a HMO plan with Primary Phif an requirements. In**



to someone with symptoms of COVID

## **II. Cardiac**

- |  |        |
|--|--------|
| 1. Have you ever been told you have high blood pressure?                             | Yes No |
| 2. Have you ever been told you have a murmur?  | Yes No |
| 3. Have you ever fainted or passed out while exercising?                             | Yes No |
| 4. Has any family member had any heart problems before the age of 50?                | Yes No |
| 5. Have you or anyone in your family been told they have Marfan's Syndrome?          | Yes No |
| 6. Have you ever been told you have an irregular heart beat or other heart problems? | Yes No |
| 7. Have you ever been evaluated for chest pain?                                      | Yes No |

If any Yes answers, please explain:

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## **III. Respiratory**

- |   |        |
|---|--------|
| 1. Do you have asthma?  | Yes No |
| 2. Do you have a history of childhood asthma?                                 | Yes No |
| 3. Do you have any trouble with your lungs?                                   | Yes No |
| 4. Do you have any difficulty with shortness of breath or coughing spells?    | Yes No |
| 5. Do you have wheezing or coughing after exercise?                           | Yes No |
| 6. Do you have any history of taking asthma medications? (pills or inhalers)  | Yes No |
| 7. Do you have a history of exposure to tuberculosis or a positive skin test? | Yes No |

If any Yes answers, please explain:

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## **IV. Neurologic**

- |   |        |
|---|--------|
| 1. Do you have a problem with frequent headaches, blurry vision or dizziness? | Yes No |
| 2. Have you ever been knocked out?  | Yes No |
| 3. Have you ever had a concussion?  | Yes No |
| 4. Have you ever had a seizure?   | Yes No |
| 5. Do you currently have seizures or epilepsy?                                | Yes No |
| 6. Do you have numbness, tingling or weakness in your arms or legs?           | Yes No |

If any Yes answers, please explain:

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## **V. Musculoskeletal**

- |  |        |
|--|--------|
| 1. Do you have any neck problems?  | Yes No |
| 2. Do you have any back problems?  | Yes No |
| 3. Have you ever had a back or neck injury?  | Yes No |
| 4. Do you have any joint problems (shoulders, elbows, hips, knees, hands, fingers, ankles, toes) | Yes No |
| 5. Do you have any incompletely healed injuries?   | Yes No |
| 6. Have you ever had a fracture or a cast?   | Yes No |
| 7. Do you have arthritis?  | Yes No |

If any Yes answers, please explain:

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**VI. Food Allergies & Dietary Restrictions**

(ex. peanuts, shellfish, vegan, lactose intolerant, etc.)

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**Participation Wellness Disclosure**

Are you aware of any reason or condition that might prevent you from participating fully in the Sound of the South Marching Band at Troy University?