

Part B—This PART MUST be completed and signed by the Athlete—or if the Athlete is under age 18 or otherwise dependant—by his/her Parent or Guardian.

PRINT HERE—NAME OF PERSON COMPLETING FORM

Check one: Athlete Parent Guardian

Give the following information about the Athlete

1. Date of Birth Mo Day Year / /	2. Male <input type="checkbox"/> Female <input type="checkbox"/>	3. Social Security Number or Student Visa No. / /	4. Area Code/Telephone No. ()
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5. Address (Street) (City) (State) (Zip)

6. Employer (Name) (Street) (City) (State) (Zip)

Area Code/Employer Telephone No.

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7. Is the Athlete covered under any other health and/or accident insurance plans? Yes No HMO
If YES, give the following information: PPO

Name or Other Insurance Company(s)	Address of Other Insurance Company(s)	Policy Numbers(s)	Name of Policyholder(s)
_____	_____	_____	_____
_____	_____	_____	_____

8. If the Athlete is under 18 or otherwise dependant, give the following information:

Name of Father or Male Guardian _____	Social Security No. / /
Place of Employment _____	
Address of Employer _____	Area Code/Employer Phone No. ()

Name of Mother or Female Guardian _____	Social Security No. / /
Place of Employment _____	
Address of Employer _____	Area Code/Employer Phone No. ()

9. If the Athlete is married, give the following information:

Name of Spouse _____	Social Security No. / /
Place of Employment _____	
Address of Employer _____	Area Code/Employer Phone No. ()

I hereby authorize any physician or medical practitioner, hospital, other organization, institution or person that has any medical records or knowledge of me or my family as diagnosis, treatment, or prognosis regarding any physical, mental, drug or alcohol condition of any and all such information to be given to Berkley Croup Companies: StarNet Insurance Company, Acadia Insurance Company, Great Divide Insurance Company or its authorized Administrator or their legal representatives. Any information obtained will not be released by the Company except to persons or organizations performing business or legal services in connection with my application or claim. A photocopy of this authorization shall be valid as the original and is valid for 24 months from the date shown below. I understand that my authorized representative or I will receive a copy of this authorization upon request.

X _____ Athlete
Signature (in writing) of Responsible party Print Name Check One: Parent Date: _____
 Guardian