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

Student and Parent(s)/Guardian(s) Information Form

300 Keokuk Street, Lincoln, IL 62656 Phone: (217) 735-7340 Fax: (217) 735-5214

Experience Outstanding LINCOLN COLLEGE

Name of Student_____ New student____ Returning student___

School Year ____ Date of Birth _____Sport (if athlete) _____

Home Address _____ Home phone_____

City_____ State_____ Zip Code_____

CHECK ONE

☐ Insurance (parents___ self___) ☐ Public Aid (what state? _____) ☐ None (no coverage available)

PARENT INFORMATION

Required

FATHER/GUARDIAN INFORMATION

Father's Name:_____

Date of Birth:_____

Employer:_____

Address:_____

Telephone: _____ _____-_____

Medical Insurance

Company or Plan: _____

Address:_____

_____

Policy Number: _____

Telephone: _____ _____-_____

Is this plan an HMO or PPO? ☐ Yes ☐ No
Is pre-authorization required to obtain treatment? ☐ Yes ☐ No
Is a second opinion required before surgery? ☐ Yes ☐ No

MOTHER/GUARDIAN INFORMATION

Mother's Name:_____

Date of Birth:_____

Employer:_____

Address:_____

Telephone: _____ _____-_____

Medical Insurance

Company or Plan: _____

Address:_____

_____

Policy Number: _____

Telephone: _____ _____-_____

Is this plan an HMO or PPO? ☐ Yes ☐ No
Is pre-authorization required to obtain treatment? ☐ Yes ☐ No
Is a second opinion required before surgery? ☐ Yes ☐ No

PARENT & STUDENT MUST SIGN BACK OF THIS FORM

Revised 3/16 DLS

STUDENT INFORMATION

(Required if student is covered under their own policy)

Medical Insurance

Company or Plan: _____

Address: _____

City/State/Zip _____

Policy Number: _____

Telephone: _____ _____-_____

Is this plan an HMO or PPO? ☐ Yes ☐ No

Is pre-authorization required to obtain treatment? ☐ Yes ☐ No

Is a second opinion required before surgery? ☐ Yes ☐ No

AUTHORIZATION – To Permit Use and Disclosure of Health Information

This Authorization was prepared by First Agency, Inc. and Lincoln College for purposes of obtaining information necessary to process a claim for benefits.

Upon presentation of the original or a 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., Lincoln College or any 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 Lincoln College or to First Agency at 5071 West H Avenue, Kalamazoo, MI 49009-8501. 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 sent in writing to the attention of the Claims Supervisor.

I understand that First Agency, Inc. may condition payment of a claim 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/Student (please print)

Name of Authorized Representative, or Parent/Guardian (please print)

Signature of Claimant/Student **Date**

Signature of Authorized Representative, or Parent/Guardian **Date**

Relationship of Authorized Representative, or Parent/Guardian to Claimant/Student