



STUDENT ID NUMBER: _____

SOUTHERN UNION - INSURANCE INFORMATION

Student Name _____ SS # _____ Date of Birth _____

Insurance Company _____

Address _____

Phone Number _____

Policy Holder Name _____ Policy Holder DOB _____

Policy Holder SSN _____ Policy # _____

Policy Holder Employer _____ Group # _____

Work Address _____

Check here if this policy is an HMO _____ or a PPO _____

I certify that the foregoing information is true and correct.

Student Signature _____ Date _____

Authorization to Release Information

I authorize any Health Care Provider, Insurance Company, Employer, Person or Organization to release information regarding medical, dental, mental, alcohol or drug abuse history, treatment or benefits payable, including disability or employment related information, to BMI Benefits, the Plan Administrator, or their employees and authorized agents for the purpose of validating and determining benefits payable. A photocopy of this authorization shall be as valid as the original.

Student Signature _____ Date _____

Please include a photocopy of the front and back of your insurance card with this form.