VISIONS
P. O. Box 220, Newport, PA 17074-0220

Medical Insurance Information Form

Please provide the following information for our insurance records.

1. Name of student ______________________________

   Address ______________________________

   ____

   Telephone Numbers Home ____________ Office ____________

2. Name of insurance carrier that provides hospitalization and medical coverage for your child.

   ____

3. Contract or policy number ______________________________

4. Group number, if applicable ______________________________

5. Your employer name, if applicable ______________________________

6. Emergency Medical Evacuation Insurance

   Policy#____________________ Carrier for this coverage____________________

   Phone contact for this coverage (*no 1-800#'s accepted*)____________________

   If you purchased coverage through Divers Alert Network: DAN ID#____________________
   (Purchase the <u>$29 basic coverage</u> from DAN w/credit card by calling 1-800-446-2671 or visit the DAN web site: www.diversalertnetwork.org)

7. Please provide two emergency contact persons other than yourself.

   Name____________________Phone____________________

   Relationship____________________ Work phone____________________

   Name____________________Phone____________________

   Relationship____________________ Work phone____________________

8. Please list the names and birthdates of younger siblings for future VISIONS mailings (Optional).

   Name____________________ Date of birth____________________

   Name____________________ Date of birth____________________