

SHCP

INSURANCE INFORMATION FORM

Parents are responsible for payment of medical treatment

Father's Information

Name of Insured _____

Address _____

Home Phone# _____ Business Phone# _____

Date of birth _____ Social Security# _____

Insurance company name _____

Address _____

Phone # _____ Policy # _____

Group # _____ Employee # _____

Mother's Information

Name of Insured _____

Address _____

Home Phone# _____ Business Phone# _____

Date of birth _____ Social Security# _____

Insurance company name _____

Address _____

Phone # _____ Policy # _____

Group # _____ Employee # _____