

**Albright College  
Gable Health Center  
P.O. Box 15234  
Reading, PA 19612-5234  
Health Insurance Information**

Student's Name \_\_\_\_\_

Student's Home Address (Street, City, State and Zip) \_\_\_\_\_

\_\_\_\_\_

Student's Home Phone Number \_\_\_\_\_

Student's Cell Phone Number \_\_\_\_\_

Student's Social Security Number \_\_\_\_\_

Student's Date of Birth \_\_\_\_\_

Student's Anticipated Year of Graduation \_\_\_\_\_

Name of Insurance Company \_\_\_\_\_

Insurance Company Address \_\_\_\_\_

Insurance Company Phone Number \_\_\_\_\_

Policy Holder and Relationship \_\_\_\_\_

Policy ID Number \_\_\_\_\_ Policy Group Number \_\_\_\_\_

Is this insurance an HMO? If so, is a referral needed from your physician for lab work and X-rays \_\_\_\_\_

Is a special laboratory needed for any kind of blood work or cultures (examples: Quest, Lab Core, etc.) if so, please specify the laboratory \_\_\_\_\_

Health Care Provider's Name \_\_\_\_\_

Health Care Provider's Telephone Number \_\_\_\_\_

Signature of Parent or Guardian \_\_\_\_\_

Today's Date \_\_\_\_\_

***It is important that we have this information updated on a yearly basis. Please provide a copy of your insurance card (front and back) with this form. Please return this form to the above address as soon as possible. Thank you for your cooperation.***

