

INSURANCE INFORMATION

TO BE COMPLETED BY PARENT OR GUARDIAN

(Please Return to Department Headquarters with Acceptance Form)

(Name of Claimant)

(Date of Birth)

(Home Address)

Person to contact in an Emergency

(Address)

(Phone Number)

During the applicant's stay at The American Legion Cadet Patrol Academy, Supplemental insurance will be provided by The American Legion **after all claims have been submitted to the individuals insurance company.**

1. Parents Name _____ Home Phone _____

Address _____
(Street) (City) (State) (Zip)

2. Father's Occupation _____ Employer _____
(Name/Address/Phone No.)

3. Mother's Occupation _____ Employer _____
(Name/Address/Phone No.)

4. List of family medical insurance policies _____
(Attach separate sheet if more space is needed)

Name of Insurance Co. _____ Group Individual HMO
Policy No.(s) _____

Address _____
(Street) (City) (State) (Zip)

To whom (Employer, Union, etc.) was policy issued _____

(Date)

(Signature of Parent or Guardian)