



Marine Military Academy

ADMISSIONS OFFICE
320 Iwo Jima Boulevard
Harlingen, TX 78550
TEL: (956) 423-6006 FAX: (956) 421-9273

CONSENT & INSURANCE FORM

Name of Cadet (Applicant): _____
Please Print Last First Middle

Date of Birth: _____ SSN: _____

Address: _____

Phone(s): _____
Home Parent/Guardian(s) Business

Name of Father/Guardian: _____ SSN: _____ DOB: __/__/__

Name of Father's Insurance Company: _____

Address: _____ Insurance Phone: _____

Policy Number(s): _____ Deductible Amount: _____

Certificate Number(s): _____ Type of Policy: () Group () Individual

Name of Mother/Guardian: _____ SSN: _____ DOB: __/__/__

Name of Mother's Insurance Company: _____

Address: _____ Insurance Phone: _____

Policy Number(s): _____ Deductible Amount: _____

Certificate Number(s): _____ Type of Policy: () Group () Individual

Is your Cadet covered under any of the above named policies? YES NO

If "yes" please indicate which plan(s): _____

Is your Cadet covered under any other health insurance policy? YES NO

If "yes" please provide insurance company's name and address: _____

_____ Policy Number(s): _____

Is your Cadet covered by a prescription card policy? YES NO

If "yes" please provide name of insurance carrier: _____ Customer Service Phone: _____

Name of Cardholder: _____ Current Coverage Date: _____

Subscriber Number: _____ Group Number: _____

**Provide a copy of the front and back of each insurance card(s).
A copy of the prescription card is required by the pharmacy for prescription processing.**

Important Note: If you currently do not have an insurance provider, you must select a pharmacy from the provided list* and contact them with your credit card number. The same applies to any medical provider your son may require assistance from. Upon notification from MMA Medical Department that your son requires services from a specific medical provider, it is your responsibility to contact that provider to make financial arrangements for payment.

This authorization applies to the Cadet (Applicant) named above:

I, as () parent, () guardian, () managing conservator, have authorized to consent to medical treatment of the foregoing minor. I hereby consent to routine medical treatment (including, but not limited to, minor illness or injury) by contracted physicians of the Marine Military Academy or physicians or other medical professionals selected by the Academy and its duly authorized officials. I also hereby give Marine Military Academy and its authorized officials authority to consent to emergency medical, surgical, or dental treatment, understanding that attempts to contact me have failed. Should injury occur to my son/ward during his attendance at the Marine Military Academy, I hereby authorize any and all hospitals, physicians or other medical providers to furnish a detailed statement of charges to the Marine Military Academy in order that they may process any applicable student accident insurance claims. The Marine Military Academy, to whom I give this authority, is related to said minor as an educational institution in which he is enrolled as a student and not financially responsible.

I certify that the insurance information shown here, to the best of my knowledge, is true, complete, and correct. A photocopy of this authorization shall be as valid as the original.

Signature of Parent/Guardian/Managing Conservator Date

*See Pharmacy and Medical Provider List on reverse side of this form