MAJOR LEAGUE SOCCER

TRY-OUT PLAYER MEDICAL INFORMATION FORM

NAME: _____

ADDRESS: _____

CITY/STATE: _____

HOME PHONE: (_____)_____ WORK PHONE: (_____)_____

BIRTH DATE: _____/_____/_____ SOCIAL SECURITY NUMBER: _____-_____-_____

IN CASE OF EMERGENCY, CONTACT:

1. _____ (_____)_____ _____
   Name Phone Relationship

2. _____ (_____)_____ _____
   Name Phone Relationship

INSURANCE INFORMATION: ***Please attach a copy of the back and front of your insurance card.***

PRIMARY INSURANCE CARRIER

NAME OF INSURANCE COMPANY: _____

ADDRESS OF COMPANY: _____

CITY/STATE: _____

INSURED'S FULL NAME: _____

YOUR RELATIONSHIP TO INSURED: _____ INSURED'S BIRTH DATE: ____/_____/_____

GROUP/PLAN/POLICY: _____ ID/SUBSCRIBER #: _____

EMPLOYER: _____ EFFECTIVE DATE OF COVERAGE: _____/_____/_____

SECONDARY INSURANCE CARRIER

NAME OF INSURANCE COMPANY: _____

ADDRESS OF COMPANY: _____

CITY/STATE: _____

INSURED'S FULL NAME: _____

YOUR RELATIONSHIP TO INSURED: _____ INSURED'S BIRTH DATE: ____/_____/_____

GROUP/PLAN/POLICY: _____ ID/SUBSCRIBER #: _____

EMPLOYER: _____ EFFECTIVE DATE OF COVERAGE: _____/_____/_____

REMINDER: ***Please attach a copy of the back and front of your insurance card.***