Print Form

ORANGE COUNTY FIRE AUTHORITY EXPLORING PROGRAM
INSURANCE AUTHORIZATION FORM

TO THE APPLICANT: *Be aware that primary, comprehensive medical insurance coverage is your responsibility and not that of the Orange County Fire Authority. Prior to acceptance as an Explorer, consent is required for use of your personal medical insurance plan for any injury or illness that occurs during participation in authorized Exploring Program activities. Limited secondary plans provided through the Boy Scouts of America cover you after exhaustion of your primary plan. Your cooperation in filling out this form as accurately and completely as possible will expedite the use of these policies should the need occur.*

EXPLORER APPLICANT INFORMATION:

POST #:_____ POST ADVISOR:_____

NAME:_____
LAST FIRST M.I

ADDRESS:_____
STREET P.O. BOX/APT. # CITY ZIP CODE

SOCIAL SECURITY #:_____ DOB:_____

CONTACT IN EMERGENCY: _____ PHONE #: _____

MEDICAL INSURANCE PRIMARY POLICY INFORMATION:

INSURANCE COMPANY:_____ PHONE #: _____

ADDRESS: _____
STREET P.O. BOX/APT. # CITY ZIP CODE

POLICY #_____ GROUP # _____ PLAN # _____

INSURED'S EMPLOYER: _____

EMPLOYER'S ADDRESS: _____
STREET P.O. BOX # CITY ZIP CODE

PHONE #: _____ EXT: _____ INSURED'S SS #: _____

CERTIFICATE OF INSURED (Read Carefully Before Signing): *The undersigned hereby affirms the foregoing information is true and correct and understands any willful misstatement or omission of material facts herein will cause forfeiture to all rights to any activities with the Exploring Program. Further, the undersigned agrees to advise the Post Advisor of any change, cancellation, or revision of policy coverage within 72 hours of said change. This form authorizes billing of the above insurance company by any hospital, medical center, or emergency room that administers medical attention for any injury or illness induced while taking part in any authorized Exploring activities.*

INSURED'S SIGNATURE: _____ DATE: _____

EXPLORING APPLICANT'S SIGNATURE: _____ DATE:_____