

# The American Legion Alabama Boys State Registration Application

Please fill out completely and send \$200.00 payment with this application. ***Please do not send one without the other it delays the application process.*** Make checks payable to: The American Legion, Dept. of Alabama. Applications must be mailed before the ***May 14<sup>th</sup> deadline.*** Mail to: The American Legion, Dept. of Alabama, P.O. Box 1069, Montgomery AL. 36101.

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_  
                    First                      MI                      Last

Preferred Name: \_\_\_\_\_ Home #: \_\_\_\_\_

Emergency Contact Info: \_\_\_\_\_  
  Name    Phone Number

Email Address: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Contact No: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Contact No: \_\_\_\_\_

***List of your School Honors:***

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***This section is to be completed by the School***

School Name: \_\_\_\_\_ County: \_\_\_\_\_

Principal: \_\_\_\_\_ Contact No: \_\_\_\_\_  
  (Signature)

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***To be filled out by the Sponsoring Agent (If it is not the School)***

Sponsored By: \_\_\_\_\_ Contact Person: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

# IMPORTANT PARENTAL STATEMENT!

**INSURANCE CLAIMS CANNOT BE PROCESSED UNLESS THE FOLLOWING SECTION HAS BEEN COMPLETED.**

The American Legion Boys State has an insurance program that provides benefits for medical expenses not covered by other family insurance. In order for us to determine benefits, we will file a claim with your family insurance company. The Legion insurance policy will pay eligible expenses not paid by your coverage. Please answer all questions. Failure to provide complete information will delay payment of allowable benefits.

Insurance Company: \_\_\_\_\_ ( ) Group ( ) Individual

Policy Number: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Policy Holder: \_\_\_\_\_ DOB: \_\_\_\_\_

Please furnish any medical conditions, allergies or any other important information about your son:

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I hereby authorize any insurance company, hospital, physician or any other person who has attended to or examined the claimant to disclose when requested to do so by The American Legion or its representative insurance company, any and all information with respect to any injury, policy coverage's, medical history, consultation, prescription or treatment and copies of all hospital or medical records. A Photostat copy of this authorization shall be considered as effective and valid as the original.

If other group insurance is involved, please attach a copy of their payment or denial notice to this claim. Processing of your claim will begin when we receive this information.

I hereby authorize Boys State to provide medical treatment in the case of an emergency or illness.

Also, we the parents agree to reimburse the amount of \$200.00 "Boys State Fee" to the sponsoring organization in the event my son decides not to attend Boys State after the **May 14<sup>th</sup> deadline**. Exceptions will be due to accident, sickness, or death in the family.

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_