

Parent/Athlete Insurance Form

Athlete's Name: _____ Sport: _____
Date of Birth: _____ Social Security Number: _____

WE DO NOT HAVE THE OPTION OF WAIVING THE REQUIREMENTS OF FILING WITH YOUR INSURANCE.

Please Note:

1. Most employers' group insurance allows dependent coverage to be continued to age 23 if the dependent is a full-time student. DO NOT drop dependent coverage while your son or daughter is participating in intercollegiate athletics.
2. Claims against your group insurance plan DO NOT increase your individual insurance premiums.

THE FOLLOWING INFORMATION AND AUTHORIZATION MUST BE FULLY COMPLETED, SIGNED, AND RETURNED. Please circle the individual listed as the insured on your primary/personal plan and complete all requested information.

Father/Guardian/Spouse/Self (circle one) Name: _____
Date of Birth: _____ Social Security Number: _____

Home Address: _____
(Street) (City, State, Zip Code)

Employer's Name: _____

Employer's Address: _____
(Street) (City, State, Zip Code)

Home Telephone Number: _____ Work Telephone Number: _____

Name of Group: _____
Insurance Company: _____ Group #: _____ Policy #: _____

Mailing Address for Claims: _____ Phone #: _____
(Street) (City, State, Zip Code)

IS YOUR DEPENDENT SON/DAUGHTER COVERED UNDER THE ABOVE POLICY? Yes: _____ No: _____

Does your insurance Require: A second opinion for surgery? Yes _____ No _____
Pre-authorization for services? Yes _____ No _____
Is your primary insurance an HMO? Yes _____ No _____
Is your primary insurance a PPO? Yes _____ No _____

Mother/Guardian/Spouse/Self (circle one) Name: _____
Date of Birth: _____ Social Security Number: _____

Home Address: _____
(Street) (City, State, Zip Code)

Employer's Name: _____

Employer's Address: _____
(Street) (City, State, Zip Code)

Home Telephone Number: _____ Work Telephone Number: _____

Name of Group: _____
Insurance Company: _____ Group #: _____ Policy #: _____

Mailing Address for Claims: _____ Phone #: _____
(Street) (City, State, Zip Code)

IS YOUR DEPENDENT SON/DAUGHTER COVERED UNDER THE ABOVE POLICY? Yes: _____ No: _____

Does your insurance Require: A second opinion for surgery? Yes _____ No _____
Pre-authorization for services? Yes _____ No _____
Is your primary insurance an HMO? Yes _____ No _____
Is your primary insurance a PPO? Yes _____ No _____

_____ I hereby authorize a claim to be filed on my behalf under the above group medical policy in the event an athletic injury is sustained by

_____ My son/daughter is NOT covered under my group insurance.

I hereby certify that the answers provided are true, complete and correct to the best of my knowledge. A photo static copy of this authorization shall be considered as effective and valid as the original

DATE: _____ Signature of Parent/Guardian: _____

