

**California State Risk Management Authority
Long Beach State Intercollegiate Athletic Insurance Questionnaire**

Accident/Injury benefits for athletes are provided on an "excess" basis. This means ATHLETE'S OWN GROUP INSURANCE OR THAT OF THE ATHLETE'S SPOUSE AND/OR PARENTS MUST BE BILLED FIRST. Benefits are available from our program only when the athlete's coverage is exhausted or does not apply. The **following information is essential** to assure that expenses are adequately and completely covered by the proper insurance. Inadequate or incomplete answers will delay payment of medical bills and may jeopardize the athlete's credit rating. No medical expenses will be paid out of institutional funds without a signed, accurate questionnaire on file. It is the athlete's sole responsibility to keep the information contained in this document current.

SECTION 1 – ATHLETE INFORMATION

Name:		Sport:	
Student ID #	Martial Status: Single <input type="checkbox"/> Married <input type="checkbox"/>	Fresh <input type="checkbox"/> Soph <input type="checkbox"/> Jr. <input type="checkbox"/> Sr <input type="checkbox"/>	
Address:			
Date of Birth:	Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>	Phone	

SECTION 2 – PARENTS INFORMATION

Father		Mother	
Name:		Name:	
Address:		Address:	
Home Phone:		Home Phone:	
Employer:		Employer:	
Address:		Address:	
Work Phone:		Work Phone:	

SECTION 3 – PARENTS MEDICAL INFORMATION

Father		Mother	
Insurance Co Name:		Insurance Co Name:	
Address:		Address:	
Phone:		Phone:	
Policy No:		Policy No:	
Policy No:		Group No:	
Work Phone:	ID No:	Work Phone:	ID No:
Type of Medical Coverage <input type="checkbox"/> HMO <input type="checkbox"/> PPO		Type of Medical Coverage <input type="checkbox"/> HMO <input type="checkbox"/> PPO	
Primary Physician (if HMO):		Primary Physician (if HMO):	
Location &/or Phone of Primary:		Location &/or Phone of Primary:	

SECTION 4 – SPOUSE INFORMATION

Name:	Date of Birth:	Phone:
Address:		
Employer:	Phone:	
Address:		

SECTION 4 – SPOUSE INSURANCE

Insurance Co Name:	Policy No:	Group No:
Address:		ID # or SS#:
Phone:	Type of Medical Coverage <input type="checkbox"/> HMO <input type="checkbox"/> PPO	

I hereby certify that the foregoing answers are true, complete, and correct to the best of my knowledge. I also hereby authorize any Insurance Company, Organization, Employer, Hospital, Physician, Surgeon, Pharmacy, or other health care provider to release any information with respect to injury, treatment, or insurance. A photo static copy of this authorization shall be considered as effective and valid as the original.

Please also provide a copy of Insurance Card(s) (Both front and back).

Parents Signature	Date
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