

UNIVERSITY OF MARYLAND SPORTS MEDICINE

Health Insurance Information / Authorization

Student-Athlete's Name _____ Social Security No. _____

Sex Male Female Date of Birth _____ Sport _____

Permanent Address _____

City _____ State _____ Zip _____ Phone _____

Campus Address _____ Cell Phone _____

Medications currently taking? _____

Allergies / Asthma / Medical Conditions? _____

FATHER'S / GUARDIAN'S INFORMATION	MOTHER'S / GUARDIAN'S INFORMATION
Name _____	Name _____
DOB _____	DOB _____
Home Address _____ _____	Home Address _____ _____
Home Phone _____	Home Phone _____
Employer _____	Employer _____
Employer Address _____	Employer Address _____
Work Phone _____	Work Phone _____

STUDENT-ATHLETE INSURANCE INFORMATION	
Insurance Company _____	Policy Owner _____
Address _____	DOB _____
City _____ State _____ Zip _____	Coverage- <input type="checkbox"/> MEDICAL <input type="checkbox"/> DENTAL <input type="checkbox"/> PRESCRIPTION <input type="checkbox"/> VISION <input type="checkbox"/> Other _____
Phone # _____	Is preauthorization necessary for medical/diagnostic services? <input type="checkbox"/> Yes <input type="checkbox"/> No Phone # _____
Type of Insurance- <input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> POS <input type="checkbox"/> Military <input type="checkbox"/> Other _____	Primary Care Physician _____
Policy / ID # _____	Physician Phone # _____
Group # _____	

PLEASE READ CAREFULLY!

- The University of Maryland Department of Intercollegiate Athletics' accident policy provides insurance for student-athletes with *injuries occurring only when participating in the play or practice of intercollegiate athletics*. This accident policy is considered "EXCESS" or "SECONDARY" to any other collectible group insurance benefits. Therefore, any claims for benefits must first be filed with the group insurance company providing coverage. Only after all available benefits have been exhausted will the University of Maryland's Department of Intercollegiate Athletics' insurance carrier consider payment for any remaining balances.
- I hereby authorize the University of Maryland Department of Intercollegiate Athletics, hospitals, & physicians connected with or provided, to furnish information to insurance carriers concerning any illness, injury, & treatments & I hereby assign to the party all payments for medical services rendered to the student-athlete.
- I agree to supply any & all information requested by my primary insurance, the University of Maryland Department of Intercollegiate Athletics & their excess insurance company in a timely manner.
- I hereby authorize the University of Maryland Department of Intercollegiate Athletics and their excess insurance company to secure & inspect copies of case history records, lab reports, diagnoses, x-rays, & any other data pertaining to the injury/illness I am receiving care for or previous confinements of disabilities relevant to the care of the injury/illness.
- I hereby authorize the University of Maryland Sports Medicine Unit and/or my coach to hospitalize & secure treatment for me for any athletic injury/illness.
- A photocopy of this authorization shall be deemed as effective & valid as the original.
- I agree to notify the University of Maryland Sports Medicine Unit immediately upon any change in the above health insurance information. If I fail to do so, I fully understand that I may be responsible for any & all charges incurred.
- I hereby certify that I have read & understand the above statements, that any & all questions have been answered to my satisfaction, & that the answers provided are true, complete, & correct to the best of my knowledge.

Policy Holder's Signature _____	Date _____
Student-Athlete's Signature _____	Date _____