

2005-2006

The University of Richmond-Department of Athletics  
HEALTH INSURANCE INFORMATION

Athlete's Name (first, middle, last) \_\_\_\_\_ Sport \_\_\_\_\_

Social Security No. \_\_\_\_\_ Year in School 1 2 3 4 5 Date of Birth \_\_\_\_\_

The University of Richmond-Department of Athletics' accident policy provides insurance coverage for a student-athlete's *injuries that occur while participating in the play or practice of intercollegiate sports*. 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 for the athlete (the parents' employers' policy or the parents' individual policy). Only after all available benefits have been exhausted will our athletic insurance company consider the payment of remaining balances.

**We, as the university, do not have the option of waiving the requirement of filing with your group insurance company.**

| FATHER'S INFORMATION   | MOTHER'S INFORMATION   |
|--|--|
| Name _____<br>SS No. _____ Date of Birth _____<br>Home Address _____<br>_____<br>Employer _____<br>Employer Address _____<br>_____<br>Home Phone _____ Work Phone _____<br>Email Address _____ Cell Phone _____  | Name _____<br>SS No. _____ Date of Birth _____<br>Home Address _____<br>_____<br>Employer _____<br>Employer Address _____<br>_____<br>Home Phone _____ Work Phone _____<br>Email Address _____ Cell Phone _____  |
| Is your son/daughter covered by a health insurance policy? ___Yes ___No<br>Is your son/daughter insured under:<br>___ Parent ___ Self ___ Other?<br>Is this policy considered your son/daughter's<br>___ Primary or ___ Secondary Insurance Policy?<br>Name of the Insurance Co. _____<br>Name of the Policy Holder _____<br>Identification # _____<br>Group Policy # _____<br>Customer Service Phone # _____<br>Pre-authorization Phone # _____<br>Claims Phone # _____<br><b>Mailing Address For Claims</b> _____<br>_____<br>___ HMO Primary Care Physician _____<br>Primary Care Physician Phone _____<br>PPO (preferred provider network) | Is your son/daughter covered by a health insurance policy? ___Yes ___No<br>Is your son/daughter insured under:<br>___ Parent ___ Self ___ Other?<br>Is this policy considered your son/daughter's<br>___ Primary or ___ Secondary Insurance Policy?<br>Name of the Insurance Co. _____<br>Name of the Policy Holder _____<br>Identification # _____<br>Group Policy # _____<br>Customer Service Phone # _____<br>Pre-authorization Phone # _____<br>Claims Phone # _____<br><b>Mailing Address For Claims</b> _____<br>_____<br>___ HMO Primary Care Physician _____<br>Primary Care Physician Phone _____<br>PPO (preferred provider network) |

**It is very important that you send (with this form) a copy of the front AND back of your health, prescription, and/or dental insurance cards.**

## Release of Information-Read Carefully

- ◆ I hereby authorize a claim to be filed on my behalf under the group medical policy in the event an injury/illness is sustained by the athlete.
- ◆ I agree to supply, in a timely manner, any and all information requested by my primary insurance, the University of Richmond, and the University's excess insurance company to expedite the claims process.
- ◆ I hereby authorize the Sports Medicine staff of the University of Richmond and/or my coach to hospitalize and secure treatment for myself for any athletic injury/illness. If the athlete is less than 18 years of age, the undersigned parent grants permission for the University of Richmond Sports Medicine staff and/or the athlete's coach to hospitalize and secure treatment for the athlete for any athletic injury/illness.
- ◆ A photo static copy of this authorization will be deemed as effective and valid as the original.
- ◆ I will notify the Sports Medicine staff of the University of Richmond immediately upon any change in the above health insurance information.
- ◆ I hereby certify that the information provided is true, complete, and correct to the best of my knowledge.
- ◆ **I, the undersigned parent, hereby authorize the University of Richmond and its excess insurance company to secure and inspect copies of the following: case history records, lab reports, diagnoses, x-rays, medical bills, insurance explanation of benefits, and any other data concerning my son/daughter's health care.**
- ◆ **I, the undersigned athlete, hereby authorize the University of Richmond and its excess insurance company to secure and inspect copies of the following: case history records, lab reports, diagnoses, x-rays, medical bills, insurance explanation of benefits, and any other data concerning my health care.**

Signature of Parent: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Athlete: \_\_\_\_\_ Date: \_\_\_\_\_

Athlete's Name (first, middle, last) \_\_\_\_\_

Social Security No. \_\_\_\_\_ Date of Birth \_\_\_\_\_

**It is very important that you send (with this form) a copy of the front AND back of your health, prescription, and/or dental insurance cards.**

Notes: