

The University of Richmond-Department of Athletics  
HEALTH INSURANCE INFORMATION

2009-2010

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 official 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/GUARDIAN INFORMATION	MOTHER'S/GUARDIAN INFORMATION
Name _____ SS No. _____ Date of Birth _____ Home Address _____ _____ Employer _____ Employer Address _____ _____ Home Phone _____ Work Phone _____ Email Address _____ Cell Phone _____	Name _____ SS No. _____ Date of Birth _____ Home Address _____ _____ Employer _____ Employer Address _____ _____ Home Phone _____ Work Phone _____ Email Address _____ Cell Phone _____
Is your son/daughter covered by a health insurance policy? <input type="checkbox"/> Yes <input type="checkbox"/> No Is your son/daughter insured under: <input type="checkbox"/> Parent <input type="checkbox"/> Self <input type="checkbox"/> Other Is this policy considered <input type="checkbox"/> Primary <input type="checkbox"/> Secondary for your son/daughter Is your insurance a(n) <input type="checkbox"/> HMO (Health Maintenance Organization) <input type="checkbox"/> PPO (Preferred Provider Organization) <input type="checkbox"/> Other Please Specify: _____ If HMO, PCP (Primary Care Physician) Name: _____ PCP (Primary Care Physician) Phone: _____ If HMO, has Guest Membership in Richmond been obtained: <input type="checkbox"/> Yes <input type="checkbox"/> No Does this policy provide medical benefits other than urgent care in Richmond: <input type="checkbox"/> Yes <input type="checkbox"/> No Name of the Major Medical Insurance Co. _____ Name of the Policy Holder _____ Identification # _____ Group Policy # _____ Customer Service Phone # _____ Pre-authorization Phone # _____ Claims Phone # _____ Mailing Address For Claims _____ _____ Does your son/daughter have dental insurance: <input type="checkbox"/> Yes <input type="checkbox"/> No	Is your son/daughter covered by a health insurance policy? <input type="checkbox"/> Yes <input type="checkbox"/> No Is your son/daughter insured under: <input type="checkbox"/> Parent <input type="checkbox"/> Self <input type="checkbox"/> Other Is this policy considered <input type="checkbox"/> Primary <input type="checkbox"/> Secondary for your son/daughter Is your insurance a(n) <input type="checkbox"/> HMO (Health Maintenance Organization) <input type="checkbox"/> PPO (Preferred Provider Organization) <input type="checkbox"/> Other Please Specify: _____ If HMO, PCP (Primary Care Physician) Name: _____ PCP (Primary Care Physician) Phone: _____ If HMO, has Guest Membership in Richmond been obtained: <input type="checkbox"/> Yes <input type="checkbox"/> No Does this policy provide medical benefits other than urgent care in Richmond: <input type="checkbox"/> Yes <input type="checkbox"/> No Name of the Major Medical Insurance Co. _____ Name of the Policy Holder _____ Identification # _____ Group Policy # _____ Customer Service Phone # _____ Pre-authorization Phone # _____ Claims Phone # _____ Mailing Address For Claims _____ _____ Does your son/daughter have dental insurance: <input type="checkbox"/> Yes <input type="checkbox"/> No

**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

#### Medical Information Release Authorization

- ◆ I / We 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, health information claim forms and any other data concerning my son/daughter’s health care.

#### Medical Insurance Payment Authorization

- ◆ I / We hereby authorize a claim to be filed on student-athlete’s behalf under my group medical policy which will be listed as primary insurance in the event an injury/illness is sustained by the athlete.
- ◆ I / We authorize the University of Richmond or its insurance agent to pay the medical service providers directly for any bills incurred from injuries/illness that are covered under the University of Richmond Secondary Athletic Insurance Policy.
- ◆ I / We 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.

#### Authorization for Medical Treatment

- ◆ I / We authorize the release of medical or other information concerning illness or injury relative to my past, present, or future participation in athletics at University of Richmond to the University of Richmond Certified Athletic Trainers, Team physician, and Athletic Coaches.
- ◆ I / We 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.

#### University of Richmond Athletic Insurance Verification

- ◆ I, \_\_\_\_\_ have read and understand the insurance coverage and claim procedure for  
guardian signature  
 University of Richmond Department of Athletics. Detailed explanation of this policy was provided to me / us in the form of **University of Richmond Student Insurance Guide** which was included with this form and is available online at [www.richmondspiders.com](http://www.richmondspiders.com) under **Sports Medicine**

#### Information Validation

- ◆ I / We will notify the Sports Medicine Staff of the University of Richmond immediately upon any change in the above health insurance information.
- ◆ I / We hereby certify that the information provided is true, complete, and correct to the best of my knowledge.
- ◆ A photo static copy of this authorization will be deemed as effective and valid as the original

*I/we have read and understand the above statements.*

Signature of Policy Holder: \_\_\_\_\_ Date: \_\_\_\_\_

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

#### PLEASE NOTE:

**This Health Insurance Information Form requires the signatures of BOTH the University of Richmond Student-Athlete and his/her parent / guardian.**

**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.**