

UC IRVINE SPORTS MEDICINE

ATHLETE/ PARENT EMERGENCY CONTACT & INSURANCE INFORMATION

Athlete's Name: _____ Date of Birth: _____ UCI Student ID #: _____

Sport (s): _____ Year: 1 2 3 4 5 E-mail Address: _____

Dear Parent(s)/Guardian of student athletes:

- **DO NOT Drop** dependent coverage while your son or daughter is participating in intercollegiate athletics. Primary insurance is required to be enrolled at UC Irvine while participating in athletics.
- The Undergraduate Student Health Insurance Plan (USHIP) from UC Irvine Student Health has restrictions and limitations and is not superior to the personal/family plan in most all cases. An exception is with the international student-athlete. USHIP was initially designed so all students have health insurance while at UC Irvine, and not to replace personal/ family coverage.
- In all injury or illness cases, UC Irvine Athletics will use the student-athlete's primary insurance.
- Our athletic accident insurance policy, is "EXCESS" or "SECONDARY" to any other collectible insurance benefits, and provides additional coverage for injuries occurring while participating in intercollegiate sport practice or play under the direct supervision of a UCI coach. It does not cover student-athletes participating in unsupervised sport related activities.
- The policy is the most comprehensive within our resources; this secondary (excess) policy is not an all-inclusive policy. The secondary insurance policy may have limitations that define the care that we are able to provide.
- The university athletic policy is not all inclusive and will only be responsible for costs deemed reasonable and customary by our insurance provider and authorized in writing by the Director of Sports Medicine.
- UC Irvine Athletics requests that **YOU do not drop** your son or daughter from the personal/family insurance plan.
- Most employers' group insurance allows dependent coverage to be continued to age 23 if the dependent is a full-time student.

PLEASE complete fully, sign and RETURN TO UC Irvine Athletics Sports Medicine.

Athlete:

UCI Local Address (if known) _____ City/State _____ Zip _____

School Phone # _____ Cell Phone #: _____

Father:

Name (last, first) _____

DOB _____

Home Address _____

City/State _____ Zip _____

Home Phone _____

Work Phone _____

Mother:

Name (last, first) _____

DOB _____

Home Address _____

City/State _____ Zip _____

Home Phone _____

Work Phone _____

Primary Insurance: Please include copy of insurance cards (front & back).

Company: _____ Insurance Address: _____

City/State : _____ Zip _____ Insurance Phone: _____

Plan/Group #: _____ Policy/Member ID#: _____

Subscriber Name: _____ Subscriber ID#: _____

Subscriber's Employer: _____ Employers' Address: _____

City/State: _____ Zip: _____ Is this insurance: HMO PPO POS EPO Indemnity

Is Student athlete covered under any DENTAL INSURANCE POLICY? YES NO

Is student-athlete covered under any VISION INSURANCE POLICY? YES NO

Have you **Enrolled** in Undergraduate Student Health Insurance Plan (USHIP) from UC Irvine Student Health? YES NO

I hereby certify that the information above is true, complete and correct to the best of my knowledge. If there are changes in coverage or an expiration of coverage, I agree to notify University of California Irvine and update the insurance information on file with the Athletic Department. I understand that if enrolled in USHIP for the fall quarter, this policy will not be active and cover any medical related costs until after the start of the academic quarter. I agree that, should it be determined at a later date that I have not accurately informed UC Irvine of collectible coverage, I will reimburse University of California or it's insurance company.

Parent/Guardian Signature and Date

Student-Athlete Signature and Date

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If the PRIMARY insurance policy DOES restrict the medical providers the student-athlete may use, please enter the corresponding policy information below:

The insurance plan is a HMO, POS, EPO policy the Primary Care Physician/ Medical Group is:

PCP/ Medical Group: _____ Phone #: _____

Address, City, Zip Code: _____

Secondary Insurance: Please include copy of insurance cards (front & back).

Company: _____ Insurance Address: _____

City/State: _____ Zip: _____ Insurance Phone: _____

Plan/Group #: _____ Policy/Member ID#: _____

Subscriber Name: _____ Subscriber ID#: _____

Subscriber's Employer: _____ Employers Address: _____

City/State: _____ Zip: _____ Is this insurance: HMO PPO POS EPO Indemnity

If the Secondary insurance policy DOES restrict the medical providers the student-athlete may use, please enter the corresponding policy information below: The Primary Care Physician/ Medical Group is:

PCP/ Medical Group: _____ Phone #: _____

Address, City, Zip Code: _____

Dental Insurance: Please include copy of insurance cards (front & back).

Company: _____ Insurance Address: _____

City/State: _____ Zip: _____ Insurance Phone: _____

Plan/Group #: _____ Policy/Member ID#: _____

Subscriber Name: _____ Subscriber ID#: _____

Subscriber's Employer: _____ Employers Address: _____

City/State: _____ Zip: _____ Is this insurance: HMO PPO POS EPO Indemnity

Return to:
UC Irvine Sports Medicine
903 W. Peltason Ave
Irvine, California 94697-4500