ATHLETIC INSURANCE INFORMATION

ATHLETES **FULL NAME** _____ AGE_____
LAST FIRST MIDDLE

SOCIAL SECURITY NUMBER _____ BIRTHDATE_____

ATHLETE'S CELL PHONE # _____

FATHER'S NAME_____ WORK TEL. # _____

CELL PHONE # _____

MOTHER'S NAME_____ WORK TEL. # _____

CELL PHONE. # _____

HOME TEL. # _____

PARENT'S ADDRESS_____
STREET CITY ZIP

EMPLOYER _____

EMPLOYER'S ADDRESS _____

DO YOU HAVE HOSPITALIZATION INSURANCE ON YOUR SON/DAUGHTER?

YES _____ NO _____

LIST THE INSURANCE COMPANY THAT YOUR SON/DAUGHTER IS COVERED UNDER.

INDICATE BY CIRCLING IF IT IS THE FATHER'S OR MOTHER'S COVERAGE

INSURANCE COMPANY _____

ADDRESS OF COMPANY _____

COMPANY PHONE # _____ POLICY / I.D. # _____

PARENT(S) SIGNATURE _____ DATE _____

EXCESS COVERAGE
IF AN ATHLETIC INJURY OCCURS, YOU SHOULD FILE WITH YOUR PERSONAL INSURANCE CARRIER FIRST.

AFTER YOUR PERSONAL INSURANCE HAS PAID;
1) OBTAIN A COPY OF THE E.O.B. (EXPLANATION OF BENEFITS) FROM YOUR INSURANCE CARRIER. 2) SEND THE E.O.B., A COPY OF THE COMPLETED CLAIM FORM AND A COPY OF THE BILLS TO THE SCHOOL'S INSURANCE CARRIER.