

UC IRVINE ATHLETE / PARENT INFORMATION

Athlete's Name: _____ Date of Birth: _____ SS#: _____

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

Dear Parent/ Athlete, **Please do not drop** your son or daughter from the family insurance plan:

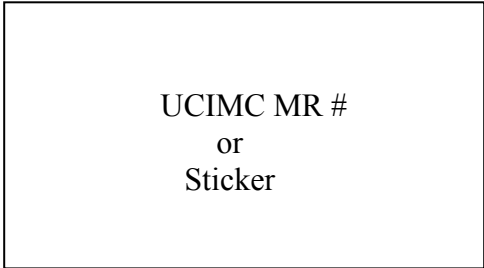
Our athletic accident policy, which provides insurance for your son or daughter for injuries occurring during participation in intercollegiate sports while under a coach or athletic trainer's supervision, is "EXCESS" or "SECONDARY" to any other collectible group insurance benefits. This simply means that any claim for benefits must first be filed with the group insurance company providing coverage to your son or daughter through your employer or your spouse's employer. After they have paid all available benefits, our athletic insurance company will pay any remaining amount that is defined as reasonable and customary by our policy. To take advantage of this excess or secondary policy, the athlete must complete a secondary insurance claim form within 90 days of initial injury.

Unfortunately, unreported injuries or injuries cared for outside athletics will not be covered. The athletic department will not pay excess charges above our insurance plan, unless authorization in writing is received prior to care. The department and its insurance carrier will not pay non-emergency, unauthorized care! Please understand this is the primary role of your health insurance.

PLEASE NOTE:

Most employers' group insurance allows dependent coverage to be continued to age 23 if the dependent is a full-time student. **DO NOT drop** dependent coverage while your son or daughter is participating in intercollegiate athletics.

THE FOLLOWING INFORMATION AND AUTHORIZATION MUST BE FULLY COMPLETED, SIGNED, AND RETURNED TO THE UC IRVINE ATHLETICS SPORTS MEDICINE



Athlete:

UCI Local Address _____ City/State _____ Zip _____

School Phone # _____ Pager/Cell Phone #: _____

Father:

Name (last, first) _____

DOB _____ SSN# _____

Home Address _____

City/State _____ Zip _____

Home Phone _____

Work Phone _____

Mother:

Name (last, first) _____

DOB _____ SSN# _____

Home Address _____

City/State _____ Zip _____

Home Phone _____

Work Phone _____

Primary Insurance:

Please include copy of insurance cards (front AND back) and any claim forms needed with this form.

Company _____

Insurance Address _____

City/State _____ Zip _____

Insurance Phone _____

Plan/Group # _____

Policy/Member ID# _____

Subscriber Name _____

Subscriber SSN# _____

Subscriber's Employer _____

Employers Address _____

City/State _____ Zip _____

Secondary Insurance:

Company _____

Insurance Address _____

City/State _____ Zip _____

Insurance Phone _____

Plan/Group # _____

Policy/Member ID# _____

Subscriber Name _____

Subscriber SSN# _____

Subscriber's Employer _____

Employers' Address _____

City/State _____ Zip _____

Is your insurance: HMO PPO POS Indemnity

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

PARENT'S SIGNATURE: _____ DATE: _____