

INSURANCE VERIFICATION FORM

THE DEPARTMENT OF INTERCOLLEGIATE ATHLETICS REQUIRES YOUR SON/DAUGHTER/DEPENDENT TO SHOW PROOF OF MEDICAL INSURANCE IN ORDER TO BE ELIGIBLE TO PARTICIPATE AS PART OF THE SPIRIT SQUAD. THIS FORM MUST BE COMPLETED AND RETURNED A.S.A.P. THANK YOU.

Son/Daughter/Dependent's Name: _____ Cheer _____ POM _____ Mascot _____

Birthdate: _____ Social Security #: _____ Sex: M _____ F _____

Father's Name _____ Date of Birth _____

Home Address _____

Street City, State, Zip Code

Employer's Name _____

Employer's Address _____

Street City, State, Zip Code

Home Telephone # _____ Work Telephone # _____

Cell # _____ Soc. Sec. # _____

Name of Group _____ or Ins. ID # _____

Insurance Company _____ Group Policy # _____

Mailing Address for Claims _____

Street City, State, Zip Code Telephone #

IS YOUR SON/DAUGHTER/DEPENDENT COVERED UNDER THE ABOVE POLICY? _____ Yes _____ No

Does your insurance require: A 2nd opinion for surgery? _____ Yes _____ No Pre-authorization for service _____ Yes _____ No

Mother's Name _____ Date of Birth _____

Home Address _____

Street City, State, Zip Code

Employer's Name _____

Employer's Address _____

Street City, State, Zip Code

Home Telephone # _____ Work Telephone # _____

Cell # _____ Soc. Sec. # _____

or Ins. ID # _____

Name of Group

Insurance Company _____ Group Policy # _____

Mailing Address for Claims _____

Street City, State, Zip Code Telephone #

IS YOUR SON/DAUGHTER/DEPENDENT COVERED UNDER THE ABOVE POLICY? _____ Yes _____ No

Does your insurance require: A 2nd opinion for surgery? _____ Yes _____ No Pre-authorization for service _____ Yes _____ No

_____ I hereby authorize a claim to be filed on my behalf under the above group/individual medical policy in the event an injury is sustained by my son/daughter/dependent.

_____ My son/daughter/dependent is NOT covered under my group/individual insurance.

I hereby certify that the answers provided are true, complete and correct to the best of my knowledge.

A photocopy of this authorization shall be considered as effective and valid as the original.

If there is a change of coverage, I agree to notify the University of Washington and update the insurance information I have on file.

Date _____ Signature of Parent/Guardian _____

OVER

DO YOU HAVE VISION OR DENTAL COVERAGE FOR YOUR SON/DAUGHTER/DEPENDENT?

VISION COVERAGE ____Yes ____No If yes,

Policy Holder ____Father ____Mother ____ Guardian

Name of Group _____

Insurance Company _____ Group Policy # _____

Mailing Address for Claims _____
Street City, State, Zip Code Telephone #

DENTAL COVERAGE ____Yes ____No If yes,

Policy Holder ____Father ____Mother ____ Guardian

Name of Group _____

Insurance Company _____ Group Policy # _____

Mailing Address for Claims _____
Street City, State, Zip Code Telephone #

_____ I hereby authorize a claim to be filed on my behalf under the above group/individual dental/vision policy in the event an injury is sustained by my son/daughter/dependent.

If there is a change of coverage, I agree to notify the University of Washington and update the medical/dental/vision insurance information I have on file.

Date _____ Signature of Parent/Guardian _____

IF POSSIBLE, PLEASE ATTACH A COPY FRONT AND BACK OF ANY MEDICAL/DENTAL/VISION CARDS RELATING TO COVERAGE FOR YOUR SON/DAUGHTER/DEPENDENT.

THE FOLLOWING INFORMATION AND AUTHORIZATION MUST BE FULLY COMPLETED, SIGNED, AND RETURNED TO:

Dept. of Intercollegiate Athletics
Attn: Athletic Training Room
Box 354070
Seattle, WA 98195-4070
(206) 543-4482
Website: <http://www.uwhuskiesatc.com/>