INSURANCE VERIFICATION FORM

IN ORDER FOR YOU (THE STUDENT-ATHLETE) TO BE ELIGIBLE TO PARTICIPATE, THIS FORM MUST BE COMPLETED AND RETURNED BY : ____________________

Athlete's Name: ____ **Sport:** ____________________________
Sex: _____M _____F

Dear Athlete: The University of Washington Department of Intercollegiate Athletics is financially responsible for athletic injuries occurring in **official practices and competitions** ONLY! **CHARGES FOR SPORTS RELATED INJURIES FOR ALL ATHLETES ARE FIRST FILED WITH THE ATHLETE'S PRIVATE INSURANCE. THE NON-ALLOWABLE AMOUNT AND/OR THE DEDUCTIBLE/CO-PAY WILL THEN BE PROCESSED BY ICA.** In addition, the University of Washington Department of Intercollegiate Athletics participates in the NCAA-sponsored catastrophic injury insurance program which provides for initial and ongoing care for student-athletes who are catastrophically injured.

Athlete's Name ____ Date of Birth____________________

Home Address ____
Street City, State, Zip Code

Home Telephone # ____________________________ Work Telephone #____________________________

Cell # ____________________________________ Social Sec. # ____________________________

Name of Group or, Insurance ID # ____________________________
Insurance Company ____ Group Policy # ____________________

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

ARE YOU COVERED UNDER THE ABOVE POLICY? _____ Yes _____ No

Does your insurance require: 2nd opinion for surgery? _____Yes _____No Pre-authorization for services? _____Yes _____No

Spouse'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 # ____________________________________ Social Sec. #____________________________

Name of Group or, Insurance ID #____________________________
Insurance Company ____ Group Policy # ____________________

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

IS THE ABOVE NAMED STUDENT-ATHLETE COVERED UNDER THE ABOVE POLICY? _____ Yes _____ No

Does your insurance require: 2nd opinion for surgery? _____Yes _____No Pre-authorization for services? _____Yes _____No

_________________ I hereby authorize a claim to be filed on my behalf under the above group/individual medical policy in the event an athletic injury is sustained by the above named student-athlete.

_________________ The above named Student-Athlete 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 ICA Student-Athlete/Spouse** ____

-OVER-

DO YOU HAVE VISION OR DENTAL COVERAGE ?

VISION COVERAGE _____Yes _____No If yes,

Policy Holder _____Student-Athlete _____Spouse

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 _____Student-Athlete _____Spouse

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 athletic injury is sustained by the above named student-athlete.

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 ICA Student-Athlete/Spouse** ____

IF POSSIBLE, PLEASE ATTACH A COPY FRONT AND BACK OF ANY MEDICAL/DENTAL/VISION CARDS.

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

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