

# UNIVERSITY OF WISCONSIN-OSHKOSH SPORTS MEDICINE

## Health Insurance Information / Authorization



Please take time to fill out the student-athlete's insurance information. If the student-athlete is covered under a parent/guardian, this form must be accompanied by signatures of the policy holder(s). This form must be filed within 48 hours of any insurance carrier change. Returning athletes with no change in coverage from previous participation must initial and date this form yearly.

(PLEASE PRINT CLEARLY IN BLUE OR BLACK INK ONLY)

Student-Athlete's Name \_\_\_\_\_ SSN \_\_\_\_\_

Sex  Male  Female Date of Birth (mm/dd/yy) \_\_\_\_\_ Sport(s) \_\_\_\_\_

Permanent Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Permanent Phone \_\_\_\_\_ Cell/School Phone \_\_\_\_\_

Emergency Contact Person \_\_\_\_\_ Contact Phone \_\_\_\_\_

Medications currently taking? \_\_\_\_\_

Allergies/Asthma? \_\_\_\_\_

PRIMARY INSURANCE	PRIMARY INSURANCE (CONT.)
Policy Holder _____	Effective Date of Policy _____
SSN _____ DOB _____	Expiration Date _____
Home Address _____	Policy Coverage Limit \$ _____
_____	Policy Deductible \$ _____ Policy Co-Pay \$ _____
Home Phone _____	Does the Policy Cover Athletic-related Injuries? __Y __N
Employer _____	
Employer Address _____	
_____	
Work Phone _____	
Insurance Company _____	
Policy / ID# _____	
Group # _____	
Insurance Company Phone # _____	
Type of Insurance ___ HMO ___ PPO ___ other	
Primary Care Physician _____	
Physician's Phone _____	
Is Authorization necessary for medical/diagnostic services? ___ YES ___ NO Phone # _____	
Is your son/daughter covered under this policy? ___ Y ___ N	

  

SECONDARY INSURANCE
Policy Holder _____
SSN _____ DOB _____
Home Address _____
_____
Home Phone _____
Employer _____
Insurance Company _____
Policy / ID# _____
Group # _____
Insurance Company Phone # _____
Type of Insurance ___ HMO ___ PPO ___ other

### Athletic Insurance Policy

All students participating in athletics must have adequate health insurance coverage for athletic injury. If a student-athlete is not covered under an adequate health insurance program, he/she must obtain coverage before participating in any University of Wisconsin-Oshkosh athletic program. The University of Wisconsin-Oshkosh and its athletic department are not financially responsible for any medical bills incurred by students involved in any University athletic program. This information sheet must be completed, signed and filed with the University Athletic Training Staff prior to any athletic participation by the student. The NCAA requires a student-athlete to have minimum coverage of \$90,000. Please attach a photocopy of your insurance card(s) and proof of adequate coverage to this form.

Primary Policy-holder's Signature \_\_\_\_\_ Date \_\_\_\_\_

Secondary Policy-holder's Signature \_\_\_\_\_ Date \_\_\_\_\_

**ACKNOWLEDGEMENT OF INSURANCE REQUIREMENTS**

I, \_\_\_\_\_, as parent, guardian or legal representative, attest  
(name, please print)

that \_\_\_\_\_ has insurance coverage under a current, in  
(student-athlete name)

force insurance policy for injuries that occur while participating in Intercollegiate Athletics at UW Oshkosh and the policy has a minimum limit of \$90,000.

If there is a material change in coverage or expiration of coverage, I agree to notify UW Oshkosh Athletic Training of this development and update the insurance information I have on file with UW Oshkosh.

I understand and agree that UW Oshkosh will assume no responsibility whatsoever for the payment of, or authorization to pay, medical expenses resulting in injuries that occur while participating in Intercollegiate Athletics at UW Oshkosh.

\_\_\_\_\_  
(signature)

\_\_\_\_\_  
(date)

THIS FORM MUST BE SIGNED AND RETURNED ALONG WITH A COPY (FRONT AND BACK) OF YOUR CURRENT INSURANCE CARD AND THE COMPLETED HEALTH INSURANCE INFORMATION/AUTHORIZATION FORM.

**Return To:**

**Wade Peitersen  
Head Athletic Trainer  
University of Wisconsin Oshkosh  
Kolf Sports Center 169-L  
Oshkosh WI 54901**