



**Health Insurance Information for 2004-2005 Academic Year**



Athlete's Name \_\_\_\_\_  
Last First MI

M/F  
(Circle)

Athlete's Home Address \_\_\_\_\_

City State Zip Code

Athlete's SS# - - Athlete's DOB / /

Sport \_\_\_\_\_

Complete Name of Insurance Company \_\_\_\_\_

Address to Mail Claim  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Policy Holder's Name \_\_\_\_\_  
Last First MI

Policy Holder's Address \_\_\_\_\_  
Number Street

City State Zip Code

Policy Holder's SS# - - Policy Holder's DOB / /

**Please copy the front and back of your insurance card and affix it below.**

Front	Back
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**Consent to Disclose Protected Health Information**

- I hereby consent to allow the UNCG Athletic Training Staff to disclose Protected Health Information concerning any injury or athletically related illness to my coaching staff and the UNCG Athletics Administration.
- I hereby consent to allow UNCG Athletic Department Personnel to disclose Protected Health Information concerning any injury or athletically related illness to my parents, legal guardians, or wards.
- I authorize payment of medical benefits to all providers of services for all services and materials they provide during the care of any injury/illness.
- I agree to supply any and all information requested by my primary insurance, UNCG and the excess insurance company, and the NCAA and their excess insurance company in a timely manner in order to expedite the claim process.
- I hereby authorize UNCG and their excess insurance company to secure and inspect copies of case history records, lab reports, diagnoses, x-rays, and other data pertaining to the injury/illness I am receiving care for or previous confinements, if disabilities relevant, to the care of the injury/illness.
- I authorize the UNCG Athletic Training staff and/or my coach to hospitalize and secure treatment for me for any athletic injury/illness. If the athlete is under 18 years of age, the undersigned parent/guardian grants permission the UNCG Athletic Training staff and/or the coach to hospitalize and secure treatment for their son/daughter/ward for any athletic injury/illness.
- This consent is irrevocable for the duration of any executed disclosure due to an athletically related illness or injury.
- A photostatic copy of this consent shall be deemed as effective and valid as the original.
- I will notify the UNCG Athletic Training staff immediately upon any change in the above health insurance information.

\_\_\_\_\_  
Athlete's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

Parent/Guardian's Name \_\_\_\_\_

Relationship \_\_\_\_\_

Home Phone \_\_\_\_\_

Work Phone \_\_\_\_\_

Parent/Guardian's Name \_\_\_\_\_

Relationship \_\_\_\_\_

Home Phone \_\_\_\_\_

Work Phone \_\_\_\_\_

Alternate Person to Contact in Case of Emergency \_\_\_\_\_

Relationship \_\_\_\_\_

Home Phone \_\_\_\_\_

Work Phone \_\_\_\_\_