UNIVERSITY OF SOUTH CAROLINA

2017-2018 Insurance Information Sheet

❑Athletic Scholarship Athlete
❑Non-Scholarship Athlete

Sport: _____

Name: _____ Date of Birth: ____/____/____ Sex: _____
Last Name First Name Middle Name

Social Security # _____--_____--_____ Student's Cell Phone: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____ Country: _____

Father: _____ Mother (include Maiden Name) :_____

HMO/PPO Information - Primary Care Physician: _____ Phone: _____

MEDICAL INSURANCE: ❑**NO MEDICAL INSURANCE COVERAGE** ❑**INTERNATIONAL STUDENT**

Insurance Company: _____ Group #: _____ Policy #: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Insurance Co. Phone Number: _____

Employer/Group Name: _____

Subscriber: _____ Relationship to Athlete: _____

Subscriber's Date of Birth ____/____/____ Subscriber's SSN: XXX-XX- _____ (Last four digits only)

CHAMPUS/TRI-CARE INFORMATION: (If Applicable)

Sponsor: _____ Relationship to Athlete: _____

Sponsor's SSN: XXX-XX- _____ (Last four digits only) ID # from card: _____

Duty Station: _____ Effective Dates: ____/____/____to ____/____/____

DENTAL INSURANCE:

Insurance Company: _____ Group #: _____ Policy #: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Insurance Co. Phone Number: _____

Employer/Group Name: _____

Subscriber: _____ Relationship to Athlete: _____

Subscriber's Date of Birth ____/____/____ Subscriber's SSN: XXX-XX- _____ (Last four digits only)

PRESCRIPTION MEDICATION COVERAGE: Rx Bin # _____ PCN/GROUP _____

I acknowledge I have read the letter regarding medical information, understand and will assist in the filing of accident claims. I attest the insurance coverage submitted is a current, in force insurance policy for injuries that occur during my participation in intercollegiate athletics. **If there is a material change in coverage or expiration of coverage, I agree to notify the University of South Carolina Athletic Medicine staff of this development and update the insurance information I have on file with them.** I understand and agree that the University of South Carolina will assume responsibility for the payment of, or authorization to pay, medical expenses resulting in injuries that occur while participating in intercollegiate athletics at the University of South Carolina – **provided I follow policies outlined in the letter received.**

_____ Date: ____/____/____ _____ Date: ____/____/____
Athlete's Signature Parent's/Guardian's Signature

Please return with a copy of the front AND back of insurance card.