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.

2/2/17