NOTICE: ALL STUDENT-ATHLETES ARE REQUIRED TO HAVE THIS FORM COMPLETED AND ON FILE IN THE ATHLETIC INSURANCE OFFICE EACH YEAR

2017-2018 Health Insurance Information

Student-Athlete's Full Name: ______________________ Sport: __________

Allergies: ______________________

PRIMARY INSURANCE COVERAGE

Name of Parent/Guardian -Carrier for Insurance Card ______________________

Workplace of above Parent/Guardian ______________________

Birth Date of above Parent/Guardian ______________________

Social Security of above Parent/Guardian ______________________

SECONDARY INSURANCE COVERAGE

Name of Parent/Guardian -Carrier for Insurance Card ______________________

Workplace of above Parent/Guardian ______________________

Birth Date of above Parent/Guardian ______________________

Social Security of above Parent/Guardian ______________________

PRIMARY CARE PHYSICIAN NAME ______________________

PHONE NUMBER ( ) ______________________

YES - I HAVE INSURANCE - SIGN AUTHORIZATION

I hereby authorize the University of Kentucky Athletic Association to submit a claim on my behalf for all covered services rendered by the Physician(s), hospital, clinic. I authorize and direct my health insurance company to issue payment directly to the provider or to the University of Kentucky Athletic Association.

Signature: ______________________ Date: __________

NO - I DO NOT HAVE INSURANCE - SIGN AUTHORIZATION

We do not carry health insurance on the above mentioned student-athlete.

Signature: ______________________ Date: __________