

HCC ATHLETIC INSURANCE INFORMATION

Must complete the following in full, and **attach a copy (front and back) of the insurance card.**

This form must be returned to the Athletic Department before Athlete's first day of practice.

Student information:

Student's Name _____ Soc. Sec. # _____

Birthdate _____ Sport _____

Home address _____

Home phone number _____ Cell phone number _____

Local address _____

Local phone number _____

Guardian/Father Information:

Name _____

Soc. Sec.# _____

Address _____

Home Phone _____

Employed _____ Yes _____ No

Work Phone _____

Guardian/Mother Information:

Name _____

Soc. Sec.# _____

Address _____

Home Phone _____

Employed _____ Yes _____ No

Work Phone _____

Does the student athlete have insurance coverage?

Please check: Yes _____ No _____

Please check: HMO _____ PPO _____

Insurance Co: _____

Address _____

Phone _____

Policy # _____

Please check: Yes _____ No _____

Please check: HMO _____ PPO _____

Insurance Co: _____

Address _____

Phone _____

Policy # _____

If you have medical insurance coverage but your son/daughter is not covered or only partially covered due to policy limitations, please explain _____

I AGREE THAT ALL INFORMATION PROVIDED IN THIS DOCUMENT IS ACCURATE AND COMPLETE TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT ANY INCORRECT OR UNDISCLOSED INFORMATION CAN RESULT IN DUPLICATE PAYMENTS CREATING A SUBSTANTIAL OVERPAYMENT. THE RESPONSIBILITY OF SUCH OVERPAYMENT WILL BE THE OBLIGATION OF THE UNDERSIGNED TO REIMBURSE IN FULL, UPON REQUEST, ALL AMOUNTS DEEMED REFUNDABLE.

BOTH PARENTS/GUARDIANS MUST SIGN

Parent/Guardian/Father: _____

Date: _____

Parent/Guardian/Mother: _____

Date: _____