

STUDENT-ATHLETE MEDICAL INSURANCE INFORMATION FORM

All student-athletes are **REQUIRED** to have valid medical insurance. Please complete this form in its entirety.
This information is confidential and will be used only for medical treatment and emergency purposes.

1. STUDENT-ATHLETE INFORMATION

Full Name (Last, First, Middle): _____ Date of Birth: _____
Student ID #: _____ Sport(s): _____ Team: _____
Home Address: _____
Street City State ZIP Code
Phone (Cell): _____ Email: _____
Emergency Contact Name: _____ Relationship: _____
Emergency Contact Phone: _____ Alternate Phone: _____

2. PRIMARY MEDICAL INSURANCE INFORMATION

Name of Insurance Carrier: _____ Policy Type: ☐ PPO ☐ HMO ☐ POS ☐ Other: _____
Policyholder Name (if not student): _____ Relationship to Student: _____
Policy/Member ID #: _____ Group #: _____ Plan Name: _____
Insurance Company Phone: _____ Customer Service Phone: _____
Claims Address (if different from above): _____

3. SECONDARY MEDICAL INSURANCE INFORMATION (IF APPLICABLE)

Name of Insurance Carrier: _____ Policy Type: ☐ PPO ☐ HMO ☐ POS ☐ Other: _____
Policyholder Name (if not student): _____ Relationship to Student: _____
Policy/Member ID #: _____ Group #: _____ Plan Name: _____
Insurance Company Phone: _____ Customer Service Phone: _____
Claims Address (if different from above): _____

4. HEALTHCARE PROVIDER INFORMATION

Primary Care Physician (Name): _____
Practice/Clinic Name: _____
Phone: _____ Fax: _____
Preferred Hospital (if known): _____

5. ADDITIONAL MEDICAL INFORMATION

Allergies (medications, foods, etc.): _____
Current Medications: _____
Chronic Medical Conditions / Past Surgeries / Injuries: _____

6. INSURANCE CARD ATTACHMENT

☐ I have attached a clear copy (front and back) of my primary insurance card and, if applicable, secondary insurance card.
**If you are unable to attach cards, you must provide all information requested above.*

7. PAYMENT RESPONSIBILITY

I understand that I (the student-athlete/parent/guardian) am financially responsible for any medical services not covered by insurance, including deductibles, co-payments, co-insurance, denied claims, and all balances that become my responsibility under the policy and applicable law.

8. IMPORTANT INFORMATION & TERMS

- **Insurance Coverage:** California Prestige University does **NOT** provide medical insurance for student-athletes.
- **Emergency Treatment:** In the event of a medical emergency, treatment will be provided as deemed necessary. You agree to be financially responsible for all charges.
- **Verification:** It is the responsibility of the student-athlete/parent/guardian to ensure that the insurance information provided is accurate and up to date. Notify the Athletic Department immediately of any changes.
- **Claims:** Providing this insurance information does not guarantee payment. Claims are subject to your insurance plan's terms and conditions. CPU is not liable for insurance claim denials.

9. ACKNOWLEDGMENT & AUTHORIZATION

I certify that the information provided above is true, correct, and complete to the best of my knowledge. I authorize California Prestige University and its representatives to use this information for medical treatment, billing, insurance claims, and communication with healthcare providers and insurance companies as needed.

Student-Athlete Signature: _____ Date: _____
(Required)
Parent/Guardian Signature (if athlete is under 18): _____ Date: _____
(Required)

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