

**ATHLETIC INSURANCE QUESTIONNAIRE**

Athlete's Name	Sport(s)
Address	Male or Female (circle one)
Phone: Home	Other
SSN	Date of Birth
Parent/Guardian's Name	
Address	SSN
Phone: Home	Work
Employer's Name and Address	
Emergency Contact	Phone
Primary Care Physician (As listed in your health plan)	Phone

**Primary Health Insurance Plan Information (Check boxes and provide information as requested)**

I am insured under my parent or guardian's employer group health insurance plan. I have verified with the insurance company that coverage is available in Kittitas County and that the policy covers injury from intercollegiate sport activities.

<i>Company Name</i>	<i>Company Phone Number</i>
<i>Name of Policy Owner</i>	<i>Policy Number</i>

I am insured under my own, individual health insurance plan. I have verified with the insurance company that coverage is available in Kittitas County and that the policy covers injury from intercollegiate sport.

<i>Company Name</i>	<i>Company Phone Number</i>
<i>Name of Policy Owner</i>	<i>Policy Number</i>

You MUST attach a photocopy of the front and back of your valid insurance I.D. card to this form.

I have read and understand the Athletic Department's health insurance Q&A information and will comply with the primary health insurance requirements. I also understand that it is the responsibility of me, my parent or guardian to report any changes in information on this form to the CWU Athletic Trainers. I further understand that I will not be allowed to participate for any intercollegiate sport without proof of acceptable health insurance coverage - there are NO exceptions!

I am not aware of any medical illness or condition that will interfere with my health and safety while participating in varsity athletics. I understand and acknowledge that a medical emergency may develop which necessitates the administration of medical care, dental care, hospitalization or surgery. Therefore, in event of such emergency, I hereby authorize Central Washington University, its authorized employee(s), representative(s) or agent(s), to arrange or provide any necessary emergency medical treatment including the administration of anesthetics and surgery.

_____ Signature of Athlete	_____ Date
_____ Signature of Policy Owner	_____ Signature of Parent or Guardian
	_____ Date