

University of Wisconsin - La Crosse
INSURANCE INFORMATION

Student-Athlete Name _____

Date of Birth _____ Sport(s) _____

I.D. # _____ Academic Year _____

The Acknowledgement of Insurance Requirements must be read and understood and this form completed **PRIOR** to the student-athlete participating in practice and/or competition.

Parent/Guardian Name _____

Address _____

Home Phone _____ Work Phone _____

Policy Holder Name _____

Relationship to Student-Athlete _____

Home Phone _____ Work Phone _____

Insurance Company Name _____

Insurance Co. Address _____

Group # _____ I.D. # _____

Effective Date Of Policy _____ Expiration Date _____

Policy Limit _____

Policy Deductible _____

Policy Co-Pay _____

Does the policy cover athletically-related injuries? Yes or No (circle one)

I have read and agree to comply with the provisions of the Acknowledgement of Insurance Requirements.

Parent/Guardian Signature and Date _____

Student-Athlete Signature and Date _____

This form must be completed and returned by AUGUST 1st

Return To:

Head Athletic Trainer
University of Wisconsin - La Crosse
144 Mitchell Hall
La Crosse, WI 54601
FAX: 608-785-8674