HEALTH INSURANCE INFORMATION

Completion and submission of this form is required of all participants in the Soccer Etc. International Camp.

Please complete this form in its entirety. Private insurance information must be provided, if applicable. If a participant does not have private health insurance, please be advised that, should a participant require medical attention, **you are responsible for paying any costs not covered by insurance.**

Participant Name _____

Participant's Address _____
Street City State Zip Code

Participant's Phone Number _____ Date of Birth _____

Insurance Company Name _____ Effective Date _____

Address of Insurance Company _____

Phone Number of Insurance Company _____ Group # _____

Policy Holder's Name _____ Policy # _____

Policy Holder's Address _____
Street City State Zip Code

Relationship to Participant _____

Contact # _____ Employee Number_____

Name of Personal or Primary Care Physician _____

Physician Address / Phone _____
_____

I hereby authorize the release of any medical information that might be needed in connection with payment for medical services.

Participant Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

I request that payment under my media cal insurance program be made directly to the provider on any bills for services rendered by that provider. I understand that I am financially responsible for fees not covered by this authorization.

Participant Signature _____ Date _____

Parent/Guardian Signature _____ Date _____