ATHLETE MEDICAL INSURANCE INFORMATION

Athlete's Name: _____ SSN: _____ DOB: _____
First Middle Last

Sport(s): _____ School Year: FR SO JR SR 5th ____ Academic Year: 20____ - 20_____

Dear Parent/Guardian:

Our athletic accident policy, which provides insurance for your son/daughter for injuries occurring while participating in the play or practice of intercollegiate sports, is "EXCESS" or "SECONDARY" to any other group insurance benefits. Benefit claims must first be filed with the group insurance company providing primary coverage to you son/daughter. After they have paid all available benefits, our athletic insurance company will consider remaining amounts based on USUAL and CUSTOMARY charges.

PLEASE NOTE:

1. We, as the school, do not have the option of waiving the requirement of filing with your group insurance.
2. Most employer's group insurance allows dependents coverage to be continued to age 23 if the dependent is a full-time student.
3. Claims against your group insurance plan DO NOT increase your individual insurance premiums.

THE FOLLOWING INFORMATION AND AUTHORIZATION MUST BE FULLY COMPLETED, SIGNED, AND RETURNED.

FATHER / GUARDIAN / SELF **INSURANCE TYPE:** PRIMARY SECONDARY

Name: _____ SSN: _____ DOB: _____

Home Address: _____City_____State: ____ Zip: _____ Home Phone: _____

Employer: _____ Work Phone: _____ Ext. _____

Address: _____ State: _____ Zip: _____

Group Insurance Company: _____ Group #: _____ Policy #: _____

Mailing Address: _____ State: _____ Zip: _____ Phone: _____

IS YOUR DEPENDENT SON/DEPENDENT DAUGHTER/SELF COVERED UNDER THE ABOVE POLICY? YES NO
Is your insurance company an HMO or PPO? (please circle, if applicable)
Does your insurance require pre-authorization for services (Yes No) or second opinion for surgery (Yes No)?

If a referral is required for services, please complete your primary care physician's information.

Name: _____ Phone: _____ Address: _____

MOTHER / GUARDIAN / SELF **INSURANCE TYPE:** PRIMARY SECONDARY

Name: _____ SSN: _____ DOB: _____

Home Address: _____City_____State: ____ Zip: _____ Home Phone: _____

Employer: _____ Work Phone: _____ Ext. _____

Address: _____ State: _____ Zip: _____

Group Insurance Company: _____ Group #: _____ Policy #: _____

Mailing Address: _____ State: _____ Zip: _____ Phone: _____

IS YOUR DEPENDENT SON/DEPENDENT DAUGHTER/SELF COVERED UNDER THE ABOVE POLICY? YES NO
Is your insurance company an HMO or PPO? (please circle if applicable)
Does your insurance require pre-authorization for services (Yes No) or second opinion for surgery (Yes No)?
If a referral is required for services, please complete your primary care physician's information.

Name: _____ Phone: _____ Address: _____

_____ I hereby authorize a claim to be filed on my behalf under the above group medical coverage in the event of an athletic injury is sustained by _____ .

_____ My son / daughter is not covered under my group medical insurance.

I hereby certify that the answers provided are true, complete, and correct to the best of my knowledge. A photostatic copy of this authorization shall be considered as effective and valid as the original.

Signature: _____ Date: _____