

PARENT'S INSURANCE FORM

E/05

Athlete's Name \_\_\_\_\_ SS# \_\_\_\_\_

Sport(s) \_\_\_\_\_ Date of Birth \_\_\_\_\_

Dear Parent:

Your son/daughter MUST be covered by medical insurance in order to participate in intercollegiate athletics. The policy cannot contain any exclusions for school-related athletic injuries. Our athletic accident policy, which provides insurance for your son or daughter for injuries occurring while participating in the play or practice of intercollegiate sports is "EXCESS" or "SECONDARY" to any other collectible group insurance benefits. This means that any claim for benefits must first be filed with the group insurance company providing coverage to your son or daughter through your employer or your spouse's employer, or an individual policy. After they have paid all available benefits, our athletic insurance company will consider remaining amounts based on USUAL and CUSTOMARY charges.

WE, AS THE SCHOOL, DO NOT HAVE THE OPTION OF WAIVING THE REQUIREMENT OF FILING WITH YOUR GROUP INSURANCE.

PLEASE NOTE:

- 1. Most employer's group insurance allows dependent coverage to be continued to age 25 if the dependent is a full-time student. DO NOT drop dependent coverage while your son or daughter is participating in intercollegiate athletics.
2. 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; please circle the individual listed as the insured on your primary/personal plan and complete all requested information.

Father/Guardian/Spouse/Self (circle one)

Name \_\_\_\_\_ Social Security # \_\_\_\_\_ DOB \_\_\_\_\_

Home Address \_\_\_\_\_ (Street) \_\_\_\_\_ (City, State & Zip Code)

Employer's Name \_\_\_\_\_

Employer's Address \_\_\_\_\_ (Street) \_\_\_\_\_ (City, State & Zip Code)

Home Telephone # \_\_\_\_\_ Work Telephone # \_\_\_\_\_

Name of Group Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Policy # \_\_\_\_\_

Mailing Address for Claims \_\_\_\_\_ (Street) \_\_\_\_\_ (City, State & Zip Code) Telephone # \_\_\_\_\_

IS YOUR DEPENDENT SON/DAUGHTER COVERED UNDER THE ABOVE POLICY? YES \_\_\_\_\_ NO \_\_\_\_\_

Does your insurance require: A second opinion for surgery? YES \_\_\_\_\_ NO \_\_\_\_\_ Is your primary insurance an HMO? YES \_\_\_\_\_ NO \_\_\_\_\_ Pre-authorization for services? YES \_\_\_\_\_ NO \_\_\_\_\_ Is your primary insurance a PPO? YES \_\_\_\_\_ NO \_\_\_\_\_

Mother/Guardian/Spouse/Self (circle one)

Name \_\_\_\_\_ Social Security # \_\_\_\_\_ DOB \_\_\_\_\_

Home Address \_\_\_\_\_ (Street) \_\_\_\_\_ (City, State & Zip Code)

Employer's Name \_\_\_\_\_

Employer's Address \_\_\_\_\_ (Street) \_\_\_\_\_ (City, State & Zip Code)

Home Telephone # \_\_\_\_\_ Work Telephone # \_\_\_\_\_

Name of Group Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Policy # \_\_\_\_\_

Mailing Address for Claims \_\_\_\_\_ (Street) \_\_\_\_\_ (City, State & Zip Code) Telephone # \_\_\_\_\_

IS YOUR DEPENDENT SON/DAUGHTER COVERED UNDER THE ABOVE POLICY? YES \_\_\_\_\_ NO \_\_\_\_\_

Does your insurance require: A second opinion for surgery? YES \_\_\_\_\_ NO \_\_\_\_\_ Is your primary insurance an HMO? YES \_\_\_\_\_ NO \_\_\_\_\_ Pre-authorization for services? YES \_\_\_\_\_ NO \_\_\_\_\_ Is your primary insurance a PPO? YES \_\_\_\_\_ NO \_\_\_\_\_

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

My son/daughter is NOT covered under my group insurance.

I hereby certify that the answers provided are true, complete and correct to the best of my knowledge. I authorize release of the above insurance information to any concerned providers. A photostatic copy of this authorization shall be considered as effective and valid as the original.

Date \_\_\_\_\_ Signature of Parent \_\_\_\_\_