2019-2020 PARENT'S EMERGENCY CONTACT/INSURANCE INFORMATION FORM

Athlete's Name _____ SS# _____

Sport _____ School _____

Dear Parent:

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. 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.
2. DO NOT drop dependent coverage while your son or daughter is participating in intercollegiate athletics.
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; please circle the individual listed as the insured on your primary/personal plan and complete all requested information.

Father/Guardian/Spouse (circle one)

Date of Birth _____

Name _____ Social Security # _____

Home Address _____
(Street) (City, State & Zip Code)

Employer's Name _____

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

Home Phone: _____ Cell Phone: _____ Work Telephone: _____

Health Insurance Company _____ Group # _____ Policy # _____

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

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 (circle one)

Date of Birth _____

Name _____ Social Security # _____

Home Address _____
(Street) (City, State & Zip Code)

Employer's Name _____

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

Home Phone: _____ Cell Phone: _____ Work Telephone: _____

Health Insurance Company _____ Group # _____ Policy # _____

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

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 photo static copy of this authorization shall be considered as effective and valid as the original.

Date _____ Signature of Parent _____