

PARENT'S INSURANCE FORM (PLEASE RETURN THIS FORM WITH A COPY OF YOUR INSURANCE ID CARD)

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 be filed first with the group insurance company providing coverage to your son or daughter through your employer or your spouse's employer. After the group policy has 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 employers' 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 sports.
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 plan and complete all requested information.

Father/Guardian/Spouse/Self (circle one)

Name _____ Date of Birth _____ SS# _____

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

Employer's Name _____

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

Home Phone _____ Work Phone _____

Group Insurance Company _____ Group # _____ Policy # _____

Claims Address _____ Phone # _____
(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 surgery? YES _____ NO _____ Is your primary insurance a PPO? YES _____ NO _____

Mother/Guardian/Spouse/Self (circle one)

Name _____ Date of Birth _____ SS# _____

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

Employer's Name _____

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

Home Phone _____ Work Phone _____

Group Insurance Company _____ Group # _____ Policy # _____

Claims Address _____ Phone # _____
(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 surgery? 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 of 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.
A photostatic copy of this authorization shall be considered as effective and valid as the original.

Date _____ Signature of Parent _____