



## **ATHLETE MEDICAL INSURANCE INFORMATION INSTRUCTIONS**

Please complete the page below.

If the insurance coverage is under one parent/guardian, information must still be completed on the other parent/guardian.

If the coverage is under the student-athlete, please complete that information appropriately.

If there is no insurance coverage, it is still necessary to complete all appropriate information on the page.

Please include a copy of the insurance card, and please write the starting and termination dates for coverage.

It may also be necessary to provide proof that the student-athlete is a full-time student to the insurance coverage. The insurance company may not tell you this. Please check with your insurance company to find out if they need such documentation.

If you do not have insurance, you may purchase insurance through the University. Please contact Pechan Health Center at 724-357-2550. They will be able to instruct you on how to purchase the insurance coverage.



# ATHLETE MEDICAL INSURANCE INFORMATION

Athlete's Name: \_\_\_\_\_ SSN: \_\_\_\_\_ DOB: \_\_\_\_\_  
First Middle Last

Sport(s): \_\_\_\_\_ School Year: FR SO JR SR 5<sup>th</sup> \_\_\_\_\_ 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: \_\_\_\_\_