SPU ATHLETICS MEDICAL INSURANCE QUESTIONNAIRE

This form is to be completed and signed *PRIOR TO TRYING OUT, PRACTICING, OR PARTICIPATING ON AN INTERCOLLEGIATE ATHLETIC TEAM*. The student-athlete is ineligible under NCAA policies until this form is completed and received by the SPU Athletic Department. Please fill in all requested information. **This document will be returned to you if information is left "blank" or answered "N/A".**

Any claim for benefits must first be filed with the insurance company providing basic coverage to the student-athlete as outlined below. After they have paid all available benefits up to the limits of the policy, SPU's insurance company will review any remaining amounts owed for potential payment, pending SPU's receipt of copies of the provider's itemized invoice(s) and your insurance company's Explanation of Benefits (EOB's).

Name of Student_____ Permanent Address _____

Sport _____ City/State/Zip_____

Date of Birth _____ Year in School _____ Phone_____

Married _____ Y _____ N Cell Phone_____

INSURANCE POLICY INFORMATION

(List policy information ONLY if student-athlete is covered under it)

Note: SPU student insurance is unacceptable since it has an athletic participation exclusion.

Policyholder Name _____ Policy Year (i.e. Jan – Dec*) _____

Relationship to Student-Athlete _____ *(this helps us determine when your deductible starts over each year)

Address/City/State/Zip _____ Policy Deductible _____

Phone _____ E-Mail _____ Policy Co-Pay _____

Employer _____ Does this policy include an exclusion for athletic-related injuries? __Y __N

Employer City & State _____ Does this policy require preauthorization? ___Y ___N

Insurance Co _____ You must attach a copy of the front & back of your insurance card

Group Policy # _____ID# _____ to this form. Have you? ___Y ___N

Claims Phone # _____ If the Student-Athlete is covered under any additional insurance

Type of Plan (Please check one) _____HMO ____PPO ____OTHER policy, please complete & attach a second form.

If other, please describe _____

Is there any reason that the student-athlete may not be fully covered under the above-referenced policy, such as out of area limitations, required referral by a primary physician, or other requirement(s) or exclusions? Please explain: _____

_____

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1. I/we hereby certify that the foregoing answers are true, complete and correct to the best of my/our knowledge.
2. I/we understand that if there is any change to the above-referenced information, it is my/our responsibility to notify the SPU Athletic Department of the change and submit a new Medical Insurance Questionnaire with updated information. I/we further understand that failure to do so will void any potential benefit coverage to be paid by SPU.
3. I/we herby authorize any Insurance Company, Organization, Employer, Hospital, Physician, Surgeon, Pharmacy, or other health care provider to release any information with respect to injury, treatment or insurance to the SPU Athletic Department for processing an insurance claim. A photostatic copy of this authorization shall be considered just as effective and valid as the original.
4. I/we have received and read the SPU Department of Athletics Medical Policies and Procedures for 2008-09 and agree to comply with its requirements.
5. I/we have attached a copy of the FRONT & BACK of the insurance card for the above-referenced policy.

Signature of Policyholder _____ Date _____

Signature of Student–Athlete _____Date _____