

Parent's Insurance Form

Athlete's Name _____ SS# _____

Sport _____

School East Tennessee State University

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 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 company will consider remaining amounts based on USAUAL 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 individuals listed as the insured on your primary/personal plan and complete all requested information.

Father/Guardian/Spouse/Self (circle one)

Name _____ DOB _____ SS# _____

Home Address _____

Street City, State and Zip Code

Employer's Name _____

Street City, State and Zip Code

Home Telephone # _____ Work Telephone # _____

Insurance Company _____ Group # _____ Policy # _____

Mailing Address for Claims _____ Telephone # _____

Street City, State, Zip

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 _____ DOB _____ SS# _____

Home Address _____

Street City, State and Zip Code

Employer's Name _____

Street City, State and Zip Code

Home Telephone # _____ Work Telephone # _____

Insurance Company _____ Group # _____ Policy # _____

Mailing Address for Claims _____ Telephone # _____

Street City, State, Zip

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 _____.

Student Athlete

A photostatic copy of this authorization shall be considered as effective and valid as the original.

Date _____ Signature of Parent _____