

## 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 requested 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 _____
SSN# _____	Phone _____
Date of Birth _____ Year in School _____	Married ___ Y ___ N

### 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 <u>exclusion</u> 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 # _____	<b>If the Student-Athlete is covered under any additional insurance</b>
Type of Plan (Please check one) ___HMO ___PPO ___OTHER	<b>policy, please complete &amp; attach a second form.</b>
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: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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 hereby 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 2007-08 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 _____

*(this helps us determine when your deductible starts over each year)*

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