

PART I: PARENT(S) / GUARDIAN / ATHLETE

SSU athletic insurance is not comprehensive. It covers accidental injury; medical conditions are not covered. Accidental injury benefits are provided on a "secondary-excess basis" and personal insurance must be billed first.

Athlete's seeking "specialty" medical care **MUST BE REFERRED** through the athletic training room. Personal physicians can be consulted for a second opinion authorized by the SSU team physician.

I/we have reviewed all of the form 1A policies and medical procedures and with my signature below confirms my/our understanding and compliance. I certify that information given below is complete and correct.

Mother's Signature _____ Date _____ Father's Signature _____ Date _____

Athlete's Signature _____ Date _____ Guardian Signature _____ Date _____

PART II: ATHLETE

Date _____ Athlete's Name _____ Sport _____
Athlete's Address _____ City _____ State _____
Athlete's Local Phone # _____ SSN# _____

I or my spouse (circle) am / am not employed. If employed, give:

Athlete's / Spouse Employer: _____ Phone # _____

Employer's Address: _____

Are you covered by personal health or spouse (circle) insurance? Yes No

Name of Insurance Company: _____ Policy # _____

PART III: PARENT/GUARDIAN - THE FOLLOWING SECTION MUST BE FULLY COMPLETED – REGARDLESS OF DEPENDANT COVERAGE

Father's Name _____ Social Security # _____
Father's Home Address _____ Phone # _____
City _____ State _____ Zip _____

Employer's Name _____ Phone # _____

Employer's Address _____

Name of your Insurance Company _____ Policy # _____

Claims Phone # _____ Type of Plan; HMO PPO Other

IS YOUR DEPENDENT SON/DAUGHTER COVERED UNDER THE ABOVE POLICY? Yes No

Does Your Insurance Require: Second Opinion for Surgery? Yes No
Pre-authorization? Yes No Phone # _____

Mother's Name _____ Social Security # _____
Mother's Home Address _____ Phone # _____
City _____ State _____ Zip _____

Employer's Name _____ Phone # _____

Employer's Address _____

Name of your Insurance Company _____ Policy # _____

Claims Phone # _____ Type of Plan; HMO PPO Other

IS YOUR DEPENDENT SON/DAUGHTER COVERED UNDER THE ABOVE POLICY? Yes No

Does Your Insurance Require: Second Opinion for Surgery? Yes No
Pre-authorization? Yes No Phone # _____