PERSONAL INSURANCE INFORMATION 2009 – 2010

Caldwell College
Athletic Training Department
Parents Insurance Information Form

OFFICIAL USE ONLY
Date Form Rec'd ______________________________
HMO_______ PPO________ EPO________ POS________

PLEASE RETURN TO:

Athletic Trainer
Caldwell College
120 Bloomfield Avenue
Caldwell, New Jersey 07006

If you have any questions, please call (973) 618-3574

FAILURE TO COMPLETE ALL BLANKS WILL RESULT IN THE FORM BEING RETURNED TO YOU AND CLAIM PROCESSING BEING DELAYED.
(Complete all blanks with information or N/A if not applicable)

ATHLETE'S NAME: ____ SPORT :_______________________________________

AGE _____________ DATE OF BIRTH ______________________________ SOCIAL SECURITY NUMBER ______________________________

HOME PH#:___________________________ **CELL PH #**:___________________________COLLEGE PH. #___________________________

COLLEGE ADDRESS: ____

HOME ADDRESS ____

TO WHOM/WHERE SHOULD THE BILL BE MAILED?____

FATHER/GUARDIAN NAME ____ PHONE NUMBER _________________________

ADDRESS ____

MOTHER/GUARDIAN NAME ____ PHONE NUMBER _________________________

ADDRESS ____

FATHER'S S.S. NUMBER______________________________________ MOTHER'S S.S.NUMBER______________________________________

FATHER'S EMPLOYER ____ PHONE NUMBER __________________________

ADDRESS ____

MOTHER'S EMPLOYER ____ PHONE NUMBER __________________________

ADDRESS ____

What type of health insurance policy(s) do you have? (**Contact your provider if you are not sure**):

Health Maintenance Organization (**HMO**)? ☐ YES ☐ NO   Exclusive Provider Organization (**EPO**)? ☐ YES ☐ NO
Preferred Provider Organization (**PPO**)? ☐ YES ☐ NO   Point of Service (**POS**) ☐ YES ☐ NO Other?____________

Major (**Primary**) Medical Plan (which covers the athlete)____

Whose name is the policy in? (ex: Father, Mother) ______________________________Policy Holder's Date of Birth____/____/________

Company/Plan Name ____

Address ____

Phone Number ____ Policy Number ____

Does this insurance plan require a referral for out-of –network care? ☐ YES ☐ NO (see the back of your card)
Does this insurance plan require notification after emergency room visits? ☐ YES ☐ NO (see the back of your card)
Does this insurance plan require a second opinion before surgery? ☐ YES ☐ NO (see the back of your card)

Basic (**Secondary**) Medical Plan (which covers the athlete) ____

Who's name is the policy in? (ex: Father, Mother) ______________________________Policy Holder's Date of Birth____/____/________

Company/Plan Name ____

Address ____

Phone Number ____ Policy Number ____

Does this insurance plan require a referral for out-of –network care? ☐ YES ☐ NO (see the back of your card)
Does this insurance plan require notification after emergency room visits? ☐ YES ☐ NO (see the back of your card)
Does your insurance plan require a second opinion before surgery? ☐ YES ☐ NO (see the back of your card)

PLEASE ATTACH A COPY OF YOUR CURRENT INSURANCE CARD(S)
FRONT AND BACK SIDES OF CARD

DENTAL INSURANCE

Is the athlete covered by dental insurance? ☐ YES ☐ NO

If yes, Company Plan/Name ____

Address ____

Phone ______________________ Policy Number ______________________

PLEASE ATTACH A COPY OF YOUR CURRENT INSURANCE CARD(S)
<u>FRONT</u> AND <u>BACK</u> SIDES OF CARD

If the athlete is covered by an HMO, PPO, EPO, or POS please be aware that we will try to go through the established referral procedures, except in the event of an emergency. This may require a trip home to see the primary care physician(PCP). If travel time is a problem (i.e. South Jersey), you may want to try and have your son/daughter reassigned to a participating physician near Caldwell College.

Name of Primary Care or Family Physician ______________________________________

Address ____

Phone Number ______________________ Date of last visit ______________

Please speak to your primary care physician before the start of the 2009-2010 season and inform them that you will not always be able to return home to visit their office. If we need to refer you to the team physician your PCP might be able to write a letter of "medical necessity" so that any treatments will be reimbursed by your HMO. <u>Some</u> (not all) HMOs will make a payment to an "out-of network" doctor if the PCP is contacted before treatment begins and a letter of medical necessity is obtained.

We hereby authorize Caldwell College and its athletic accident insurance carrier to inspect or secure copies of case history records, laboratory reports, diagnosis, x-rays, and any other data covering this and/or previous confinements and/or disabilities. A photo static copy of this authorization shall be deemed effective and valid as the original.

We authorize Caldwell College's athletic insurance company to pay the medical vendors directly for any bills from accidents that may occur while participating in Caldwell College sponsored athletics.

Parents Signature ______________________________ Date ______________
[Required for all students]

Athlete's Signature ______________________________ Date ______________

IMPORTANT NOTE: CALDWELL COLLEGE <u>WILL NOT</u> GUARANTEE THAT THE ATHLETIC ACCIDENT POLICY WILL PAY ALL FEES IN FULL.
ALL BILLS ARE ULTIMATELY THE STUDENT'S RESPONSIBILITY.

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NOTARIZATION FORM

If the father, mother, or guardian is covered by an employer paid health plan, and the coverage **does not** extend to the Caldwell College student athlete, please ask the employer to provide the College with a letter stating that the child is not covered. This will help speed up the payment of claims.

IF THE ATHLETE HAS NO FAMILY OR PERSONAL MEDICAL INSURANCE COVERAGE, PLEASE READ THE STATEMENT BELOW AND HAVE YOUR SIGNATURE(S) NOTARIZED.

I hereby state that there is no group, individual, or personal medical insurance coverage on this student-athlete as asked for above. Should we obtain any such insurance coverage, we agree to provide the requested information immediately. Failure to do so will prevent claims processing.

Parent/Guardian Signature ____

Athlete's Signature ____

Athlete's Social Security Number ____

State of ____ County of ___________________________

Be it remembered that on the __________ day of ___________________________ before me, the subscriber, a Notary of the State of ________________________________ personally appeared ____________________________________, who I am satisfied is the person named in and who executed the above instrument, acknowledged that he/she signed, sealed, and delivered that same as his/her voluntary act and deed, for the uses and purposes therein expressed.

Notary Public ____

My commission expires ____________________________________