



PARENT'S INSURANCE FORM 2011-2012

Athlete's Name _____ Sport _____

Address _____ City _____ State _____

Zip _____ DOB ____/____/____

PLEASE NOTE: 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 first 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 insurance company will consider remaining amounts based on USUAL and CUSTOMARY charges.

WE, AS THE SCHOOL, DO NOT HAVE THE OPTION OF WAIVING THE REQUIREMENT OF FILING WITH YOUR GROUP INSURANCE.

- Please understand:
1. Most employers' group insurance allows dependent coverage to be continued to age 23 if the dependent is a full-time student. DO NOT drop dependent coverage while your son or daughter is participating in intercollegiate athletics. Many companies will allow you to change the area of coverage for your son or daughter.
 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 BY THE INSURANCE POLICY HOLDER.

Please circle the individual listed as the insured on your primary/personal plan and complete all information.

Father / Mother / Guardian / Spouse / Self (circle one)

Insurers Full Name _____ Insurers' Date of Birth _____

Insurers Home Address _____
Street City State Zip Code

Home Telephone # _____ Cell # _____ Email Address _____

Please list other parent full name, Cell # and Email Address

Full Name _____ Cell # _____ Email Address _____

Employer's Name _____ Work Telephone # _____

Employer's Address _____
Street City State Zip Code

Name of Group _____
Insurance company I.D. # _____ Group # _____

Address for Claims _____
Street City State Zip Code Telephone # _____

Does your insurance require: A second opinion for surgery? YES ___ NO ___
Is your primary insurance an HMO? YES ___ NO ___
Referral or Pre-authorization for services? YES ___ NO ___
Is your primary insurance a PPO? YES ___ NO ___

Does your insurance cover: ER Services in the Memphis area? YES ___ NO ___
MRIs in the Memphis area? YES ___ NO ___
CT Scans in the Memphis area? YES ___ NO ___

Which hospital is In-Network with your insurance?(Circle One) Baptist / Methodist / St. Francis

Does your insurance company require MRIs and CT Scans to be performed within the first 24 hours after an injury? YES ___ NO ___

What is your insurance deductible? _____ Do you have a co-pay? YES ___ NO ___ How Much? _____

Name of Athletes Primary Care Physician _____ Office Phone # _____

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 _____ (son or daughter). I hereby certify that the answers provided are true, complete, and correct to the best of my knowledge. A photostatic copy of this authorization shall be considered as effective and valid as the original.

Date _____ Signature of Parent _____