

**Montclair State University
Athletic Training Department
Insurance Information Form**

2006-07

FAILURE TO COMPLETE ALL BLANKS WILL RESULT IN MEDICAL INELIGIBILITY

(Complete all blanks clearly with information or N/A if not applicable)

Today's Date: _____

Athlete Name: _____ Gender: _____ SS #: _____

Sport: _____ Age: _____ Birth Date: _____ Year at MSU: 1 2 3 4 5 TR

Student's College Address: _____

College Phone: _____ Home Phone: _____ Cell Phone: _____

Home Address: _____

PARENT/GUARDIAN INFORMATION

Father/Guardian: _____

SS#: _____

Address (if different): _____

Phone: _____ Cell Phone: _____

Employer: _____

Address: _____

Work Phone: _____

Mother/Guardian: _____

SS#: _____

Address (if different): _____

Phone: _____ Cell Phone: _____

Employer: _____

Address: _____

Work Phone: _____

In case of an emergency and a Parent/Guardian can not be reached, please contact:

Name: _____ Relationship: _____ Phone: _____

Address: _____

FAMILY PHYSICIAN INFORMATION

Name of Primary Care or Family Physician (PCP): _____ Phone: _____

Address: _____

INSURANCE INFORMATION

- **If no family/personal insurance** please give a brief explanation as to why. _____

If NO family/personal insurance, please also complete the notarization page 3!

****Please attach a copy (both front & back) of your Family/Personal Insurance Card with this form****

Father/Guardian/Personal Insurance (circle one)

Is this plan primary or secondary?
Is the athlete covered by this plan? Yes No
Are Referrals Necessary for care? Yes No
Type of plan (circle one): HMO PPO Traditional Other _____
Out of network benefits? Yes No
Insurance Company Name: _____
Address: _____

Policy/ID#: _____ Group#/Plan#: _____
Phone: _____ Fax: _____

- Does this insurance plan require a second opinion before surgery? **Yes** _____ **No** _____
- Does this insurance plan require pre-authorization for diagnostic or surgical procedures? **Yes** _____ **No** _____

Dental Insurance? Yes No
Company Name: _____
Address: _____
Policy#: _____
Phone: _____ Fax: _____

Mother/Guardian/Personal Insurance (circle one)

Is this plan primary or secondary?
Is the athlete covered by this plan? Yes No
Are Referrals Necessary for care? Yes No
Type of plan (circle one): HMO PPO Traditional Other _____
Out of network benefits? Yes No
Insurance Company Name: _____
Address: _____

Policy/ID# _____ Group/Plan# _____
Phone: _____

- Does this insurance plan require a second opinion before surgery? **Yes** _____ **No** _____
- Does this insurance plan require pre-authorization for diagnostic or surgical procedures? **Yes** _____ **No** _____

Dental Insurance? Yes No
Company Name: _____
Address: _____
Policy#: _____
Phone: _____ Fax: _____

AUTHORIZATION TO DISCLOSE MEDICAL RECORDS AND DIRECT PAYMENT TO MEDICAL PROVIDERS

We/I hereby authorize any insurance company, hospital, physician, or other person who has attended or examined the claimant to disclose, when requested to do so, all information with respect to any injury, policy coverage, medical history, laboratory tests, x-rays, diagnostic tests, consultation or treatment, and copies of all hospitals or medical records.

We/I also understand that MSU’s athletic policy only covers athletic injuries and only the portion of bills that are not covered by family or personal insurance are eligible. I/We understand that MSU’s athletic policy is an **Excess policy**. I/we understand that **I/we ARE ULTIMATELY RESPONSIBLE FOR ALL BILLS.**

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

Athlete - Print Name Signature Date

Parent/Guardian – Print Name Signature Date

Signature to Decline

MSU WILL NOT GUARANTEE THAT THE ATHLETIC ACCIDENT POLICY WILL PAY ALL FEES IN FULL.

PLEASE ATTACH A COPY OF YOUR FAMILY/PERSONAL INSURANCE CARD(S) WITH THIS FORM. WE NEED BOTH THE FRONT AND BACK OF THE CARD.

Please return this form by mail or in person on or before your scheduled physical date to:

**Athletic Training Department
Intercollegiate Athletics / Montclair State University
Montclair, NJ 07043**

(973) 655-5250, Fax (973) 655-5436 Ask for Cindy Dormann or John Davis

Notarization Form
(Only if no family/personal insurance policy)

If you have no family or personal Medical Insurance Coverage you must read the Statement Below and Have this form Notarized.

If the athlete or family has:

- 1) **No medical insurance**; or
- 2) The father, mother, or guardian is covered by an employer paid health plan and the coverage **does not extend** to the MSU student athlete; or
- 3) The policy **does not cover Intercollegiate sport injuries**,

please ask the employer to provide MSU with a letter stating that the child is not covered.

This will help speed up the payment of claims.

I/We 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 insurance coverage; I/we agree to provide the requested information. Failure to do so will prevent claims processing.

Parent signature: _____

Athlete signature: _____

State of: _____

Social Security #: _____

County of: _____

Be it remembered that on the _____ day of _____
200__ 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, and acknowledge that he signed, sealed,
and delivered that same as his voluntary act and deed, for the uses and purposes
therein expressed.

Notary Public

My commission expires: _____

MSU WILL NOT GUARANTEE THAT THE ATHLETIC POLICY WILL PAY ALL FEES IN FULL.

THIS FORM CAN BE THROWN AWAY IF NOT NEEDED