CARLOW UNIVERSITY

Athletic Insurance Information

(Please type/print using **Black Ink**) **PLEASE NOTE:** PARENT OR GUARDIAN INSURANCE COVERAGE IS PRIMARY COVERAGE. CARLOW UNIVERSITY PROVIDES SECONDARY INSURANCE COVERAGE THAT WILL BE APPLIED AFTER PRIMARY COVERAGE.

Student Name______________________________________ Sport(s)_____________________________________

Soc. Sec. #______________________ Date of Birth____________________ Campus Phone_________________

Permanent Address____ City________________________________

State___________ Zip___________ Phone____

Insurance Policy Holder's Name______________________________ Relationship _______________________

Address____

Phone No. ___________________________

Employer ____ Phone No. ____________________________

Emergency Contact _______________________________________ Relationship __________________________

Address____

Phone No. ___________________________

Employer____ Phone No. ___________________________

Do you have medical insurance to cover this athlete?__YES __NO **(IF you checked No, please see below)**

*******The Policy Holder must sign this form***

Name of Insurance Company ____

Policy #: ID #________________________ Group #__________________ Phone__________________________

Is this an HMO or PPO? __YES __NO If YES, which one _________________________________

IF YOUR INSURANCE CARRIER IS AN HMO OR PPO, ARE THERE ANY EMERGENCY CARE PROVISIONS THAT WER SHOULD BE AWARE OF IN THE EVENT OF THE NEED FOR "EMERGENCY, ON-SITE CARE"? PLEASE EXPLAIN ANY SUCH PROVISIONS ON THE LINES BELOW.

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I hereby authorize Carlow University and associated Insurance Group to inspect or secure copies of case history records, laboratory reports, diagnoses, x-rays, and any other data covering this and/ or previous confinements and/ or disabilities. A photocopy of this authorization shall be deemed as effective and valid as the original.

We authorize Carlow University and associated Insurance Group to pay the medical vendors direct for any bills incurred from accidents that are covered under the coverage purchased by Carlow University.

I/ WE AGREE THAT ALL INFORMATION IN THIS DOCUMENT IS ACCURATE AND COMPLETE TO THE BEST OF MY/ OUR KNOWLEDGE. I/ WE UNDRESTAND THAT ANY INCORRECT OT INDISCLOSED INFORMATION CAN RESULT IN DUPLICATE PAYMENTS CTEATING A SUBSTANTIAL OVERPAYMENT. THE RESPOSBILITY OF SUCH OVERPAYMENT WILL BE THE OBLIGATION OF THE UNDERSIGNED TO REIMBURSE IN FULL, UPON REQUEST. ALL AMOUNTS DEEMED REFUNDABLE.

PARENT/ GUARDIAN/ POLICY HOLDER__________________________________ DATE________________

STUDENT ATHELETE____ DATE________________

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YOU MUST HAVE MEDICAL INSURANCE IN ORDER TO PARTICIPATE IN ATHLETICS AT CARLOW UNIVERSITY. IF YOU DO NOT HAVE INSURANCE, IT CAN BE PURCHASED THROUGH THE UNIVRESITY. ALL LINES OF THIS FORM MUST BE COMPLETED. PLEASE BE SURE THAT IF YOUR INSURANCE IS HMO/ PPO THAT YOU HAVE LISTED ALL NECESSARY STEPS TO BE COMPLETED IN THE EVENT OF AN EMERGENCY OT CLAIM THAT NEEDS TO BE REPORTED . FAILURE TO DO SO MAY RESULT IN DELAYS IN PROCESSING.

IF YOU REQUIRE MORE INFORMATION ABOUT STUDENT MEDICAL INSURANCE, PLEASE CALL THE OFFICE OF STUDENT LIFE AT (412) 578-6690