

Insurance Information

Personal Information

Student Name				Birthday	
Student Phone Number				Student Sport if applicable:	
Name of Person Insurance is under				Insurer's Birthday	
Street Address	City	State (abbr.)	Zip	Insurer's phone	

Primary Insurance Information

Insurance Company	Insurance Company Address		City	State	Zip
Employer Name	Employer Address		City	State	Zip
Insurance Company Phone	Employer Phone	Employee ID#	Group Number	Policy Number	

Is your medical coverage through a Health Maintenance Organization (HMO)? Yes No

Is a referral needed? Yes No If yes, best number to call for referral? _____

Is your medical coverage through a Preferred Provider Organization (PPO)? Yes No

Is a referral needed? Yes No If yes, best number to call for referral? _____

Is your Insurance Plan an Indemnity plan? Yes No

Does your insurance plan require a referral from your PCP to be seen by a specialist (Ortho)? Yes No

Is your Insurance Plan a government funded program (Medicaid, Military?) Yes No

It is the student's and/or parent's responsibility to obtain any needed referrals. All students are responsible to know how their insurance works in this area and how to obtain a referral. They will need their own insurance card or a copy.

Must include a copy of insurance card (front and back) along with this completed form.

Student/Parent (if applicable) Signature _____

Date _____

Insurance Information continued ONLY Student Athletes must complete this page

It is your responsibility to obtain any needed referrals and to know the details of your insurance requirements regarding referrals. (If you do not receive or obtain an authorization from your primary carrier, you may be penalized by 50% by the second athletic policy.) You should keep your insurance card, or a copy, available and attach a clear copy (front and back) to this form.

If you participate in athletic programs or activities, you should contact your insurance company to verify that your primary insurance covers all types of injuries that occur away from home, including those that result from participating in athletic programs. You should also know the effective date of coverage, any deductible and coinsurance amounts, and any coverage exclusions, including exclusions for athletic related injuries.

If your primary insurance does not contain appropriate coverage for athletic participation, you must enroll in an Individual Intercollegiate Sports Plan at an annual additional fee billed into your student tuition bill. Federally subsidized insurance plans (i.e. Medicaid and Tri Care plans) do not cover intercollegiate athletic injuries on a primary basis. If you have one these plans, you must enroll in the Individual Intercollegiate Sports Plan.

If your primary insurance plan does not allow you to be seen out of state but instead requires you to be seen in your home state if you are an out-of-state athlete, it is highly encouraged that you enroll in the Individual Intercollegiate Sports Plan for an annual additional fee billed to your student tuition bill so that you can be seen locally during your time at Thiel College.

If your coverage changes due to job changes, new year plans, or other reasons, it is your responsibility to communicate those changes to AT staff as soon as you are aware to avoid any issues.

Please check either Yes or No to the statements below:

- 1.) My insurance carrier provides coverage in the greater Pittsburgh area. Yes No
- 2.) I have verified that my insurance covers athletic injuries. Yes No
- 3.) My insurance is a government sponsored Plan (Medicaid, Tri Care Plan.) Yes No
- 4.) I would like to enroll in the Individual Intercollegiate Sports Plan. Yes No

*****If you have Primary Insurance that covers athletic injuries, you do not need to enroll in the Individual Intercollegiate Sports Plan.**

If you answered Yes to question #4, you must email the athletic training staff.

By signing below, I hereby authorize a claim to be filed on my behalf under the group above medical policy in the event an athletic injury is sustained. In addition, I authorize any physician and/or hospital to release any information related to injury or illness.

Your signature below is your acknowledgement that you maintain primary health insurance coverage, and have provided details of your insurance information in the Insurance Information section of this form.

Student Name Printed	Student Signature	Date
Parent/Guardian Name Printed (if under 18)	Parent/Guardian Signature	Date