

IDAHO STATE UNIVERSITY
STUDENT-ATHLETE INSURANCE INFORMATION FORM
Academic Year 2011/2012

ISU Athletics requires verification of primary personal health insurance coverage for all student-athletes. ISU athletic department provides an athletic injury insurance policy for injuries sustained by student-athletes while participating in intercollegiate athletics. This injury policy is "IN EXCESS" or "SECONDARY" to any other collectible group or individual policy benefits. Therefore, for the athletic injury policy to pay, the primary insurance coverage must be exhausted. The student-athlete will not be allowed to participate in any conditioning, practice or competition until this form is completed and returned. Please be as thorough as possible.

Athlete's Name _____ Bengal ID# _____ Birthday _____ Sport _____

Local Address and Phone Number _____

Please complete the following and ATTACH A COPY OF THE FRONT AND BACK OF YOUR HEALTH INSURANCE CARD.

I am/will be covered under the ISU Student Health Insurance Plan only ____ Yes ____ No. (This is not a waiver of the student health insurance offered at ISU – all students must complete an Insurance waiver each semester)

Primary Health Insurance Information:

Policy Holder's Name _____

Date of Birth _____ Relation to Student-Athlete _____

Home Address _____
Street _____ City, State, Zip _____
code _____

Employer's Name and Address _____

Home Telephone Number _____ Work Telephone Number _____

Name of Insurance Company _____ HMO: ____ Yes ____ No

Policy # _____ Group # _____ Subscriber # _____

Mailing address for claims _____

_____ Telephone: _____

Effective Date of Policy _____ Expiration Date: _____

Policy Limit _____ Policy Deductible: _____

Policy Co-Pay _____

Does your insurance require: A second opinion for surgery ____ YES ____ NO Pre-authorization for surgery ____ YES ____ NO

Do you have other secondary insurance? _____ Please provide copies and information for secondary policy _____

PRESCRIPTION PLAN INFORMATION (front and back copy of prescription card must be attached)

____ Yes, I do have a prescription benefit covered by insurance.

____ If I go to a "Network Participating Pharmacy" I have a co-pay and the pharmacy files my claim.

____ I have to pay for all prescriptions then submit my pharmacy charges for reimbursement.

____ No, I do not have any prescription benefits through insurance.

I/We agree that all information provided is accurate and complete to the best of my/our knowledge.

I/We understand that any incorrect or undisclosed information can result in duplicate payments creating an overpayment. The responsibility of such overpayment will be the obligation of the undersigned to reimburse in full, upon request, all amounts deemed refundable.

I/We authorize any insurance company, organization, employer, hospital, physician, surgeon, or pharmacy to release any information with respect to injury, treatment, or insurance. A photo copy of this authorization shall be considered as effective and valid as the original.

I/We understand that all medical care incurred for an athletic injury will be processed by the primary carrier before the athletic injury policy can be utilized.

I/We are aware that any athletic grant-in-aid may be canceled if I give false information on any institutional form.

I/We certify to the best of my/our knowledge that the above information is accurate and will notify Idaho State University Athletic Department of any changes if they occur during the upcoming academic school year. Medical expenses are payable only for medical expenses incurred within 104 weeks after the date of the accident causing the accidental bodily injury.

I/We understand that the athlete must seek medical care and treatment within 90 days of a covered accident to be eligible for benefits.

AUTHORIZATION FOR RELEASE OF INFORMATION

I, as the Patient named below (or as the Personal Representative of the Patient named below), hereby authorize the use or disclosure of my individually identifiable health information (“Protected Health Information” or “PHI”), including secure web access to claims data (if provided by the plan), with respect to the [Idaho State University Student Health Insurance Plan and the Idaho State Sports University Athletic Policy] as described below

Patient name: _____ ID Number: _____

Persons/organization providing the information:

Persons/Organization Receiving Information:

IEC Group, Inc. dba AmeriBen/IEC Group

Idaho State University Athletic Insurance
(Coordinator and the Idaho State University Athletic Trainer)

Idaho State University Athletic Insurance
(Coordinator and the Idaho State University Athletic Trainer)

IEC Group, Inc. dba AmeriBen/IEC Group

Person/organization receiving the information:

Type of PHI to be disclosed: [e.g., claim date of service, claim dollar amount, treating provider name, accumulator information, claim type, network contractual adjustment amount, ineligible amount, co-payment amount, deductible amount, covered expenses, payment percentage, claim payment amount.]

Purpose(s) to which disclosure of PHI will be limited: [e.g., claims processing for the benefit of the participant in the form of; claim status; claim payment status, claim appeal status and decision, claim processing details, plan benefit information.]

I further understand and agree:

1. This Authorization will expire 2 years after the termination of my participation in the Plan;
2. I may revoke this Authorization at any time by notifying the providing person/organization in writing;
3. I may see and copy the information described on this form if I ask for it;
4. I am not required to sign this form to enroll in, or receive my health care benefits under, the Plan; and
5. The information that is used or disclosed under this Authorization may be re-disclosed by the receiving entities, but only for the specific purposes authorized.

I certify that I have read and understand this Authorization, and that the information in it is true and correct.

SIGNING THIS AUTHORIZATION IS NOT A PREREQUISITE TO YOUR PARTICIPATION IN THE IDAHO STATE UNIVERSITY STUDENT HEALTH INSURANCE AND IDAHO STATE SPORTS UNIVERSITY ATHLETIC PLAN.

_____ Student-Athlete’s Name

_____ Date Student-Athlete Signature

**Please complete in full and return in the provided return envelope to:
Idaho State University
Department of Athletics
Campus Box 8173
Pocatello, Idaho 83209**