Idaho State University
2019-20 Student-Athlete Health Insurance

The ISU Department of Athletics requires verification of primary personal health insurance coverage for all student-athletes. The Department provides an athletic injury insurance policy (Idaho State University Sports Athletic Plan) 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 and a copy of the insurance card has been provided. Please be as thorough as possible.

Student-Athlete Name_____ Cell Phone_____

Bengal ID#_____ Date of Birth_____ Sport_____

Please complete the following and ATTACH A COPY OF THE FRONT AND BACK of your health insurance card.

PRIMARY HEALTH INSURANCE INFORMATION

Policy Holder's Name_____

Date of Birth_____ Relationship to Student-Athlete_____

Home Address_____
Street City, State, Zip Code

Home Telephone Number_____ Work Telephone Number_____

Employer's Name_____

Employer's Address_____
Street City, State, Zip Code

Name of Insurance Company_____ HMO: ☐ Yes ☐ No

Policy #_____ Group #_____ Subscriber #_____

Mailing address for claims_____
Street City, State, Zip Code

Telephone number for claims_____

Effective Date of Policy_____ Expiration Date_____

Does your insurance require: a second opinion for surgery? ☐ Yes ☐ No
pre-authorization for surgery? ☐ Yes ☐ No

Do you have other secondary insurance? ☐ No
☐ Yes – Insurance Name_____

If yes, please provide a copy of the front and back of the secondary insurance card. Also, provide the same information for the secondary insurance as provided for the primary insurance above.

****You are responsible to inform the Athletic Insurance Coordinator of any changes to your primary (and, if applicable, secondary) health insurance information. Failure to do so could result in unpaid claims.****

PRESCRIPTION PLAN INFORMATION

☐ Yes, I do have a prescription benefit covered by insurance. (Mark below which payment plan is used and a **copy of the front and back of the prescription card must be attached**.)

☐ I go to a "Network Participating Pharmacy," make 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.

TERMS

- 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 understand that all medical care incurred for the primary carrier will process an athletic injury 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 the Department of Athletics 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 covered athletic 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**.** Any delinquent bills resulting in bad credit due to non-compliance with insurance company requests may be the responsibility of the student-athlete and/or his/her parent(s)/guardian(s).

Student-Athlete's Printed Name | Student-Athlete's Signature | Date

If student-athlete is under 18 years of age: _____

Parent's/Guardian's Signature | Date

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient name_____ **Bengal ID #**_____

authorizes the release of protected health information (PHI), including insurance claims information and medical information for the processing of medical claims from health care providers and student-athlete's primary (and, if applicable, secondary) health insurance plan(s) to the ISU Athletic Insurance Coordinator and the Idaho State University Sports Athletic Plan.

Entity 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 for Release of Protected Health Information 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; and
4. The information that is disclosed under this Authorization may be re-disclosed by the receiving entities.

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 SPORTS ATHLETIC PLAN; HOWEVER, NOT SIGNING COULD JEOPARDIZE PROCESSING OF ANY OUTSTANDING CLAIMS.

Student-Athlete's Printed Name | Student-Athlete's Signature | Date

If student-athlete is under 18 years of age: _____

Parent's/Guardian's Signature | Date

Please return completed form with the front and back copy of the insurance card to

Email: sains@isu.edu
Fax: (208) 282-4063

Mail: Idaho State University
921 S 8th Ave Stop 8173
Pocatello, ID 83209

Due by July 1, 2019
or prior to summer workouts.

Original: Athletic Insurance Coordinator