

## EMERGENCY CONTACT & INSURANCE INFORMATION FORM STUDENT ATHLETE

ACADEMIC YEAR 2010-2011

I accept the Mercyhurst sponsored Highmark PPO Blue Health Insurance Plan with the following coverage:

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Individual coverage<br>\$1,224.00 Annual<br>\$416.00 per Trimester | <input type="checkbox"/> 2-Person coverage<br>\$3,185.00 Annual<br>\$1,070.00 per Trimester | <input type="checkbox"/> Family coverage<br>\$3,804.00 Annual<br>\$1,277.00 per Trimester |
|---|---|---|

Please fill out this form completely and legibly, sign and return this form and accompanying payment to:  
 Mercyhurst College, Attn: Anita Higgins, Egan Hall 323, 501 East 38<sup>th</sup> St., Erie, PA 16546

**STUDENT INFORMATION:**

Name _____	Student ID# _____
Date of Birth _____ SSN _____	Sport _____
College Address _____	Campus Phone _____
Home Address _____	Home Phone _____
City _____ State _____	Zip _____ Country _____

**PARENT INFORMATION:**

Father/Guardian Name _____ Address _____ City _____ State _____ Zip _____ Phone (____) _____ Employer _____	Mother/Guardian Name _____ Address _____ City _____ State _____ Zip _____ Phone (____) _____ Employer _____
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**INSURANCE INFORMATION:**

Mercyhurst College provides secondary EXCESS COVERAGE insurance for your son/daughter for injuries sustained while participating in the play or practice of intercollegiate sports. This simply means that it pays benefits only after taking into consideration those amounts payable under any other insurance plans you may carry on the student athlete. We, as the school, do not have the option of waiving this provision.

**PRIMARY INSURANCE INFORMATION**

Name of Policyholder \_\_\_\_\_  
 Policyholder SS# \_\_\_\_\_  
 Policyholder Date of Birth \_\_\_\_\_  
 Insurance Company Name \_\_\_\_\_  
 Plan Name/Type \_\_\_\_\_  
 Group Number \_\_\_\_\_  
 Policy / ID Number \_\_\_\_\_  
 Claims Mailing Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Ins. Co. Phone (\_\_\_\_) \_\_\_\_\_

**SECONDARY INSURANCE INFORMATION**

Name of Policyholder \_\_\_\_\_  
 Policyholder SS# \_\_\_\_\_  
 Policyholder Date of Birth \_\_\_\_\_  
 Insurance Company Name \_\_\_\_\_  
 Plan Name/Type \_\_\_\_\_  
 Group Number \_\_\_\_\_  
 Policy / ID Number \_\_\_\_\_  
 Claims Mailing Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Ins. Co. Phone (\_\_\_\_) \_\_\_\_\_

**CHECK ONE AND SIGN BELOW: (It is recommended that International Student Athletes choose Option "B")**

A. \_\_\_\_\_ I hereby authorize the Mercyhurst College athletic department to file a claim on my behalf under the above named group medical policy in the event that an athletic injury is sustained by my son/daughter. The insurance information I have provided above is correct to my knowledge, currently valid, and provides coverage for athletic injuries that may occur while at Mercyhurst College. This coverage has limits of at least \$90,000. If there is a material change in the coverage or expiration of coverage, I agree to notify Mercyhurst College of this development and update the insurance information I have on file with Mercyhurst College.

B. \_\_\_\_\_ My son/daughter is not covered under any group insurance (or the insurance we have does not cover athletic injuries, but I am willing to pay for coverage under the Highmark Blue Cross/Blue Shield PPO Blue plan offered through Mercyhurst College. I understand that I must enroll and purchase this plan prior to participation and pay all premiums for the entire year during which the insurance is provided.

I hereby authorize Mercyhurst College and its affiliated and contracted insurance companies, brokers and administrators to inspect or secure copies of case history records, laboratory reports, diagnoses, x-rays, MRI's, and any other data and medical records covering this and/or previous confinements and/or disabilities for the above named student athlete. A photo static copy of this authorization shall be deemed as effective and valid as the original. We authorize that the college or its insurance agent may pay the medical vendors directly for any bills incurred from accidents that are covered under the coverage purchased by the college.

Signature of parent \_\_\_\_\_ Date \_\_\_\_\_

Signature of athlete \_\_\_\_\_ Date \_\_\_\_\_

**\*\*Please provide a legible copy of the athlete's current insurance card front and back and include it with this form\*\***



## ACKNOWLEDGEMENT OF INSURANCE REQUIREMENTS FOR ATHLETES

I, \_\_\_\_\_, attest that I have insurance coverage under a current,  
(Student athlete name)

in-force insurance policy for injuries that occur during my participation in intercollegiate athletics. This coverage has limits of at least \$90,000 that includes coverage for sport-related injuries.

If there is a material change in coverage or expiration of coverage, I agree to notify Mercyhurst College of this development and update the insurance information I have on file with Mercyhurst College.

I understand and agree the Mercyhurst University will assume no responsibility whatsoever for the payment of, or authorization to pay, medical expenses resulting in injuries that occur while participating in intercollegiate athletics at Mercyhurst College.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**THIS FORM MUST BE SIGNED AND RETURNED TO MERCYHURST COLLEGE BY  
July 31, 2010.**

**Return to:**

**Mercyhurst College  
Attn: Anita Higgins  
323 Egan Hall  
501 East 38<sup>th</sup> Street  
Erie, PA 16546**

**YOU MUST INCLUDE A COPY (FRONT AND BACK) OF YOUR CURRENT INSURANCE CARD AND THE  
COMPLETED EMERGENCY CONTACT AND INSURANCE INFORMATION FORM.**