

Idaho State University 2020-21 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 pol-

icy 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		Ce	ll Phone		
Bengal ID#	Date of Birth		Sport		
Please complete the following	and ATTACH A COPY OF THE	FRONT ANI	D BACK of your h	nealth insurance o	card.
PRIMARY HEALTH INSURANCE INI	FORMATION				
Policy Holder's Name					
Date of Birth	Relationship to Stude	nt-Athlete_			
Home Address					
	Street			City, State, Zip	Code
	Wo		ne Number		
Employer's Name					
Employer's Address					
Name of Insurance Company	Street			City, State, Zip HMO: ☐ Yes	
	Group #				
•					
	Street			City, State, Zip	Code
Effective Date of Policy	Expiratio	n Date			
Does your insurance require:	a second opinion for surgery				
Do you have other secondary i	pre-authorization for surgery	/? ∐Yes	□ No		
Do you have other secondary i	☐ Yes – Insurance N	Name			
If yes, please provide a copy of	f the <u>front and back</u> of the seco				infor-
mation for the secondary insur	rance as provided for the prima	ary insurand	ce above.		
	form the Athletic Insurance Co ealth insurance information. Fa				
PRESCRIPTION PLAN INFORMATION	<u>DN</u>				
	— tion benefit covered by insurar	ice. (Mark b	pelow which payi	ment plan is used	and a
· · · · · · · · · · · · · · · · · · ·	of the prescription card must			·	
G	Participating Pharmacy," make		•	•	
• •	prescriptions then submit my pescription benefits through ins	•	harges for reimb	ursement.	
☐ No, I do not have any pre	sscription benefits through insi	arance.			

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 ag	101		
ii student-atmete is under 10 years or ag	Parent's/Guardian's Signature	Date	
AUTHORIZATION FOR RELEASE OF PROTECTED HEALT	TH INFORMATION		
Patient name	Bengal ID #		
authorizes the release of protected health information for the processing of medical cla (and, if applicable, secondary) health insurance p	aims from health care providers and student-ath	lete's primary	
Idaho State University Sports Athletic Plan.			

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 Mail: Idaho State University Fax: (208) 282-4063 921 S 8th Ave Stop 8173

921 S 8th Ave Stop 8173 Pocatello, ID 83209 Due by July 1, 2020 or prior to summer workouts.