Baruch College

Re: Intercollegiate Athletic Accident Insurance

Dear Parents/Guardian:

The college for the benefit of our student athletes provides comprehensive Intercollegiate Athletic Insurance. This coverage is for injuries resulting from a specific accident occurring during regular season practice, play and travel of the student’s particular sport. A $150.00 deductible is applied per injury, in the event Baruch College’s Athletic Insurance Plan needs to be implemented. The payment of the deductible is the sole responsibility of the Student – Athlete.

The NCAA’s Catastrophic Injury Insurance Program covers student-athletes who are catastrophically injured while participating in a covered intercollegiate athletic activity. The policy has a $75,000 deductible and is supplemental coverage. More information on this program can be found on the NCAA’s web-site at www.ncaa.org.

Baruch College’s Athletic Insurance Plan is provided on an excess or secondary basis. This means that should an injury occur that requires medical attention outside our athletic training department, any claims for reimbursement of medical expenses incurred by the athlete must be first submitted to your family insurance. If a balance remains after your family insurance company has processed the bill, or if the claim is denied, please send a copy of all itemized bills and an Explanation of Benefits (EOB) Statement from your insurance company (or a copy of the denial letter) to the College Athletic Department (c/o Athletic Trainer). The Athletic Department will submit the claim to our insurance company for processing. Your cooperation in processing all claims in a timely fashion is greatly appreciated.

This accident insurance does not cover:
* Injuries sustained prior to athlete attending Baruch College
* Medical Expenses incurred due to sickness or illness.
* Injury not directly related to official practice, play or travel for the sport.

In the event that your son/daughter is injured while participating in intercollegiate athletics, it is important for us to know about any medical coverage you may have to avoid delays in proper medical care and processing of any claims. No student-athlete will be allowed to participate in intercollegiate athletics without the following questionnaire completed, signed and returned. Therefore, please complete the “Insurance Questionnaire” attached to this letter. Please note, it is vital that all requested information be completed in its entirety.

If you have any questions or concerns, please feel free to contact our office. Thank you and best wishes for a healthy academic and athletic year.

Sincerely,

Heather Cayward
Head Athletic Trainer
INSURANCE QUESTIONNAIRE

Name of student ________________________________  Soc. Sec. # _______________________________
Address ________________________________ _______ Date of Birth_______ _____ Sport _____________
________________________________________ Phone no. ________________________________

Emergency Contact:
Name__________________________________  Relationship to student______________________
Phone no. ______________________________   Add. Phone no. ___________________________

Is the above student covered under any existing policies, including Medicaid? ______________
If yes, please fill in the information below. If no, skip section below, date and sign sheet.
Policy Holder __________________________________  Relationship to student _____________________
Phone no. _____________________________________  Address_____________ _____________________
Employer _____________________________________   __________________________________
Insurance Co. __________________________________  Member ID# _____________________________
Plan name ____________________________________  Policy no. _______________________________
Ins. Co. Address _______________________________  Type of plan _____________________________
_______________________________________  Ins. Co. Phone no. _________________________

If you have a secondary insurance company, please fill in the above information on a separate sheet of paper and attach it to the back of this form.

List any allergies to medication/other _______________________________________________________________
List any medications/ supplements you are currently taking ______________________________________________

I/WE AGREE THAT ALL INFORMATION PROVIDED IN THIS DOCUMENT IS ACCURATE AND COMPLETE TO THE
BEST OF MY/OUR KNOWLEDGE. I/WE UNDERSTAND THAT ANY INCORRECT OR UNDISCLOSED
INFORMATION COULD RESULT IN INSURANCE FRAUD OR INCORRECT PAYMENTS. THE RESPONSIBILITY OF
FRAUD/ INCORRECT PAYMENTS WILL BE THE OBLIGATION OF THE UNDERSIGNED TO REIMBURSE IN FULL,
UPON REQUEST.

Parent/ Guardian _____________________________________  Date __________________
Student _____________________________________________  Date __________________

BY SIGNING BELOW, I HEREBY GIVE CONSENT FOR MEDICAL TREATMENT IN THE EVENT I SUFFER AN
INJURY/ ILLNESS AND I AM UNABLE TO MAKE SUCH A DECISION MYSELF AS A RESULT OF THE INJURY/ ILLNESS.

Parent/ Guardian _____________________________________  Date __________________
Student _____________________________________________  Date __________________