SUNY New Paltz Intercollegiate Athletic Insurance Questionnaire

Accident / injury benefits for student athletes are provided on an excess basis. This means the student athlete's **OWN PERSONAL INSURANCE or that of the ATHLETE'S SPOUSE OR PARENTS MUST BE BILLED FIRST.** Benefits are available from the secondary policy only when the student athlete's are exhausted. A $1000.00 deductible must be satisfied either by the primary insurance company or out of pocket by the student athlete and or parent / guardian before the secondary policy go into effect. The following information is essential to assure that expenses are adequately and completely covered by the proper insurance. Inadequate or incomplete answers will delay the payment of medical bills. No medical expenses will be paid by the secondary policy without a signed, accurate questionnaire on file, which will be updated yearly. It is the student athlete's responsibility to keep this information up to date.

Section 1 – Student Athlete Information

Name____________________________ Single___ Married____ Eligibility Year □ FR □ SO □ JR □ SR

SS#_________________________ DOB____________________________ Sex: M___ F___

Permanent Address____

School (local) Address ____

Home Phone______________________ Cell Phone________________________ Local Phone___________________

Section 2 – Parent/Guardian Information

Father

Name__________________________________

Address________________________________

Home phone____________________________

Cell Phone______________________________

Employer_______________________________

Employer Address________________________

Work Phone ____________________________

DOB _______________________

Mother

Name__________________________________

Address________________________________

Home phone____________________________

Cell Phone______________________________

Employer_______________________________

Employer Address________________________

Work Phone ____________________________

DOB ________________________

Primary Medical Insurance

Primary Holder's Name ___________________

Insurance Co. Name______________________

Address________________________________

____

Member Services Phone #_________________

Policy #________________________________

Group #________________________________

ID or SS#_______________

Circle one: HMO PPO

Secondary Medical Insurance

Secondary Holder's Name__________________

Insurance Co. Name______________________

Address________________________________

____

Member Services Phone #__________________

Policy # ________________________________

Group #________________________________

ID or SS#_______________

Circle one: HMO PPO

I hereby certify that the foregoing answers are true, complete, and correct to the best of my knowledge. I also hereby authorize any insurance company, organization, employer, hospital, MD, or other health care provider to release any information with respect to injury, treatment, or insurance. A photocopy of this authorization shall be considered as effective and valid as the original.

ATHLETE SIGNATURE___________________________ DATE _______________ SPORT________________

Parent or Guardian Signature if under 18 ____ Date _________