

TO: Johnson State College Student-Athletes and Their Parents

FROM: JSC Athletic Training

SUBJECT: Insurance for the 2007-08 Academic Year

Please note, all Johnson State College student-athletes must provide evidence of insurance that includes coverage for athletically-related injuries. This is a pre-requisite for practice and competition. No student will be allowed to participate in any way until such evidence of current insurance coverage is on file with the Johnson State College department of athletics. This requirement is fulfilled by sending a photocopy of both sides of your insurance card and by filling out the acknowledgement of insurance form. By signing the enclosed acknowledgement of insurance requirements form, you are stating that you are aware of the requirements and that your policy meets the minimum coverage limits.

Insurance coverage must have a minimum of at least \$75,000 and cover athletically-related injuries. If your insurance does not meet these requirements, Johnson State College will review the individual circumstances to determine if the insurance meets the insurance coverage requirement.

The NCAA's Catastrophic Injury Insurance Program covers student-athletes who are catastrophically injured while participating in a covered intercollegiate athletic activity (subject to all policy terms and conditions). The policy has a \$75,000 deductible. This coverage does not qualify as the basic coverage required for participation in athletics at Johnson State College. It is a supplemental coverage in the event of a catastrophic injury. More information on this program can be found on the NCAA's web-site at [www.ncaa.org](http://www.ncaa.org).

Johnson State College will assume no responsibility whatsoever for the payment of, or authorization to pay, medical expenses resulting from injuries that occur while participating in intercollegiate athletics.

If you have questions regarding terms of your coverage, you should contact your insurer immediately. Please be sure to note if there are any exclusions in your policy regarding athletically-related injuries.

If you have questions regarding this requirement, please contact us at 802-635-1487.

**EMERGENCY CONTACT INFORMATION**

Name (Last, First): \_\_\_\_\_ Date: \_\_\_\_\_

Sport(s): \_\_\_\_\_ Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age: \_\_\_\_\_ Year in School (grade): \_\_\_\_\_

Local (JSC) Address: \_\_\_\_\_

Local JSC Phone: \_\_\_\_\_ JSC Dorm Room #: \_\_\_\_\_

Parent Name: \_\_\_\_\_ Parent Address: \_\_\_\_\_

Parent Phone: \_\_\_\_\_ Alternate Phone (Work/Cell): \_\_\_\_\_

Secondary Emergency Contact: \_\_\_\_\_

Contact Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

**INSURANCE INFORMATION**

Insurance Company: \_\_\_\_\_

Policy Holders Name: \_\_\_\_\_ Relationship to Student-Athlete: \_\_\_\_\_

Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Group/Plan Number: \_\_\_\_\_ Identification Number: \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_

Effective date of policy: \_\_\_\_ Expiration Date: \_\_\_\_\_ Does this policy cover athletically related injuries? \_\_\_\_

Insurance Phone: \_\_\_\_\_ Check One: HMO? \_\_\_\_ PPO? \_\_\_\_

DO YOU NEED A REFERRAL FROM YOUR PRIMARY CARE PHYSICIAN TO SEE A SPECIALIST? YES NO

Doctor's Name (PCP)? \_\_\_\_\_ Doc's Phone: \_\_\_\_\_ Doc's Fax: \_\_\_\_\_

**Secondary Insurance: (Dental)**

Insurance Company: \_\_\_\_\_

Policy Holders Name: \_\_\_\_\_ Relationship to Student-Athlete: \_\_\_\_\_

Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Group/Plan Number: \_\_\_\_\_ Identification Number: \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_

Effective date of policy: \_\_\_\_ Expiration Date: \_\_\_\_\_ Insurance Phone: \_\_\_\_\_

**I have read and agree to comply with the provisions of the Acknowledgement of Insurance Requirement.**

\_\_\_\_\_  
Parent/Guardian Signature Date

\_\_\_\_\_  
Student Athlete Signature Date

**This form must be completed in its entirety and returned to :** Renee Breault, ATC SHAPE Facility  
Johnson State College 337 College Hill Johnson, VT 05656

## **Acknowledgement of Insurance Requirements**

### **For Parents:**

I, \_\_\_\_\_, as parent/guardian or legal representative, attest that  
(name, please print)

\_\_\_\_\_ has insurance coverage under a current, in force insurance  
(student-athlete name)

policy for injuries that occur while he/she is participating in intercollegiate athletics.

### **For Student-Athletes:**

I, \_\_\_\_\_, attest that I have insurance coverage under a current, in force  
Insurance policy for injuries that occur during participation in intercollegiate athletics.

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

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

\_\_\_\_\_  
(signature)

\_\_\_\_\_  
(date)

**This form must be signed and returned to Johnson State College.**

Return to:  
Renee Breault, ATC  
SHAPE Facility  
Johnson State College  
337 College Hill  
Johnson , VT 05656

**You must include a copy (front and back) of your current insurance card and the completed emergency contact and insurance information form.**