PRIMARY INSURANCE INFORMATION

Athlete's Name_____ Sport_____ Date_____

Our athletic accident policy, which provides insurance for injuries occurring while participating in the play or practice of intercollegiate sports, is 'EXCESS' or secondary to any other collectible group insurance benefits. This simply means that any claim for benefits must first be filed with the group insurance company providing coverage for the athlete. After all available benefits have been paid, our athletic insurance company would pay the remaining amounts. NORTHWEST UNIVERSITY **DOES NOT** HAVE THE OPTION OF WAIVING THE REQUIREMENT OF FILING WITH YOUR GROUP INSURANCE BY THE POLICY HOLDER, FIRST. **Please Note:**

1. Most employers' group insurance allows dependent coverage to be continued to age 23 if the dependent is a full time student DO NOT drop dependent coverage while the athlete is participating in intercollegiate athletics.
2. Claims against your group insurance plan DO NOT increase your individual insurance premiums
3. Northwest University cannot file insurance claims on behalf of an athlete. The policyholder must file claims for the athlete.

THE FOLLOWING INFORMATION AND AUTHORIZATION MUST BE FULLY COMPLETED, SIGNED AND RETURNED TO:
Larry Brown, M.S., A.T.C. Northwest University Athletic Trainer

Policy Holder's Name_____ Date of Birth_____ Social Security #_____

Relationship to athlete: _____

Home Address: _____

Employer's Name: _____

Employer's Address: _____

Home Telephone # _____ Work Telephone # _____

Name of Group
Insurance Company_____ ID # _____Group # _____

Mailing Address for Claims_____ Claims Phone #_____

IS THE ATHLETE COVERED UNDER THE ABOVE POLICY FOR INTERCOLLEGIATE ATHLETIC INJURIES? Yes_____ No_____

Does your insurance require: A second opinion for surgery? Yes____ No____
Pre-Authorization for Services? Yes____ No____

IS THE ATHLETE COVERED BY SECONDARY INSURANCE? _____ NO _____YES
If YES, please provide the following information on the back of this page: (Policy Holder's name, SSN, Date of Birth, Relationship to Athlete, Home Address, Employer's Name and Address, Home and work Telephone number, Name of Insurance Company, Group Number, Policy Number, Claims Mailing Address and Phone Number).

Please - Copy, Cut, & Affix a copy of both Front and Back of Insurance Card Below prior to submitting this form

Front	**Back**

I herby authorize a claim to be filed on my behalf under the above group medical policy in the event an athletic injury is sustained by: _____

I herby certify that the answers provided are true, complete and correct to the best of my knowledge. A photo static copy of this authorization shall be considered as effective an valid as the original.

Date_____ Signature of Policy Holder_____