

PARENT ATHLETIC INSURANCE INFORMATION FORM

PARENTS/GUARDIAN TO COMPLETE AND RETURN TO: Bethel College
Attn:
300 East 27th Street
North Newton KS 67117
Fax: (316) 284-5830

FAILURE TO COMPLETE ALL BLANKS WILL RESULT IN CLAIMS PROCESSING DELAYS. NOTE:
Complete all blanks. If information is not applicable, indicate the reason it is not (e.g. deceased, divorced, unknown).

I. Name of Athlete _____ Sport(s) _____
(First, MI, Last)
Social Security # _____ Date of Birth _____
College Address _____ Cell Phone _____
Home Address _____ Home Phone _____
City _____ State _____ Zip _____

II. Father/Guardian _____ Mother/Guardian _____
(First, MI, Last) (First, MI, Last)
Social Security # _____ Social Security # _____
Date of Birth _____ Date of Birth _____
Address _____ Address _____

III. Employer _____ Employer _____
Telephone _____ Telephone _____

IV. Primary Medical Insurance Company _____ Secondary Medical Insurance Company _____
Address _____ Address _____
Policy Number _____ Policy Number _____
Phone Number _____ Phone Number _____
Name of Insured _____ Name of Insured _____

I have enrolled in the Student Insurance Plan offered through Bethel College. **Yes** ____ **No** ____

I have enrolled in the Supplemental Athletic Insurance Option offered through Bethel College. **Yes** ____ **No** ____

a. If No to the above question, I understand that I or my insurance company will be responsible for the first \$2,000.00 of an athletic injury claim before the College Athletic Insurance takes effect. _____ **(Initials of athlete)** Please see attached insurance policy & procedures.

Is the company or plan listed above considered a Health Maintenance Organization (HMO)? ____ or a Preferred Provider Organization (PPO)? ____

Does your insurance or plan require a second opinion before surgery? **Yes** ____ **No** ____

I hereby authorize Bethel College and Student Assurance Services, Inc. of Wichita, Kansas, to inspect or secure copies of case history records, laboratory reports, diagnoses, x-rays, and any other data covering this and/or previous confinements and/or disabilities. A Photostat copy of this authorization shall be deemed as effective and valid as the original.

We authorize that the college/university or its insurance to pay the medical vendors direct for any bills incurred from accidents that are covered under the coverage purchased by the college/university.

Parent's Signature _____ Date _____

Student's Signature _____ Date _____

*** Please Return this form to your Head Coach ***

General Authorization/Consent Form for Student Athletes

I understand that my performance as an athlete and the reputation of my team and the college are dependent, in part, on my conduct as an individual. I hereby agree to accept and abide by the standards, rules, and regulations set forth by the college, the athletic director and the coaches' for the sport(s) in which I participate. In addition:

I hereby give my consent for practice and play in intercollegiate athletic events while a student at Bethel College.

I also grant permission for treatment deemed necessary for a condition arising during participation in these activities, including medical or surgical treatment recommended by a medical doctor. I agree to the need for a pre-participation medical examination.

I understand while benefits derived from intercollegiate athletic participation is great, there are also calculated risks involved in such competition.

I understand that an element of risk is present that could result in acute injury, chronic conditions, total paralysis, or death in all such participation.

NAME OF STUDENT ATHLETE _____

PARENTAL/GUARDIAN SIGNATURE* _____ **DATE** _____

STUDENT-ATHLETE SIGNATURE _____ **DATE** _____

***Student athlete 18 or under need signature of parent/guardian.**

PLEASE PRINT YOUR NAME _____

***Student athlete 18 or under need signature of parent/guardian.**