



VERIFICATION OF INSURANCE

STUDENT 'S NAME: _____ SSN: _____

SPORT: _____ COACH: _____ DOB: _____

ADDRESS: _____ CELL: _____

Do you have health insurance? Yes No

POLICY HOLDERS NAME: _____ RELATIONSHIP: _____

INSURANCE COMPANY NAME: _____

POLICY NUMBER: _____ GROUP NUMBER: _____

Ins Phone: _____ Ins Address: _____

I understand that my insurance company will provide my primary coverage, and **the College's insurance is secondary coverage**. I hereby certify that all the above information is true, complete and accurate to the best of the knowledge.

Each student/athlete must present proof of insurance, either coverage provided by their parent/guardian, spouse, or any other policy that covers them before he/she will be allowed to compete or practice.

The student/athlete plan will pay up to 100% when you use the CCN Managed Care network **after** you primary insurance has paid provider. If non-CCN providers are used the CCN allowance may be less than the amount billed. If you do not use a CCN provider, you could face a substantial balance not covered under this plan.

Should a student/athlete want to obtain a second opinion from a physician of their choice or go to a physician without a referral from the athletic trainers, they do so on their own accord and at their own expense

\$ 100 Deductible for Football/Soccer \$ 50 Deductible for all other sports

Student's Signature

Date signed

Place Insurance Card Here

