May 1, 2010

Dear Student-Athlete & Parent/Guardian,

On behalf of the Stony Brook University Department of Athletics I would like to inform you of the athletic insurance provided for all participants on SBU intercollegiate athletic teams. It is essential that all policies and procedures are followed in order for any claims to be processed. Delay in payment and/or loss of coverage may result if these guidelines are not followed. Please review this document carefully.

## Type of coverage

The Stony Brook University Department of Athletics provides an ***Excess (Secondary) Policy*** for its student-athletes. This requires that ***all bills must first be submitted to the student-athletes primary insurance***. The student-athletes personal medical policy will be the primary coverage and must always be exhausted first.

## About the Athletic Accident Insurance Policy

1. The policy **only covers intercollegiate athletic injuries**, which occur during participation in coach supervised intercollegiate activities (i.e. practice, games, and travel);
2. The policy **DOES NOT** cover general illnesses;
3. All off-campus medical referrals (i.e. physical therapy, diagnostic tests, doctor appointments, etc) must have prior approval from the SBU Sports Medicine Staff, before reimbursement is considered;
4. Please notify SBU Sports Medicine Staff of any policy changes or cancellations. Failure to do so will void secondary athletics insurance coverage.
5. Dental injuries **ARE NOT** covered if the sport requires that a mouth guard be worn and the student-athlete was not wearing one properly at the time of the injury.

## Procedures to Follow When an Injury Occurs

If any of the following procedures are not followed, the SBU Department of Athletics will **not** be responsible for any charges incurred due to examination and/or treatment:

1. All athletic injuries must be reported to the sports medicine staff within one day of occurrence;
2. The sports medicine staff will coordinate all medical referrals;
3. All claims are made through the athletic training room;
4. ***All bills must first be submitted to the student-athletes primary carrier, The SBU Athletics insurance information will be provided to the provider for his/her office to submit to once primary insurance has been processed. In the event the office does not/will not submit to secondary, it is your responsibility to submit any outstanding itemized bills, Explanation of Benefits (EOB's), and/or letter of denial to your respective athletic trainer****;*
5. If seeking a second opinion, you must ensure that the provider accepts your insurance and is in-network prior to obtaining any services from them.

****Important Notes:**

1. Every semester you must waive or enroll in the Stony Brook University student health insurance plan on your SOLAR account;
2. Notify your insurance carrier once you/your child becomes age 19 as a full time student status; this issue has presented obstacles for student-athletes in the past.

All questions or correspondence should be addressed to:


Stony Brook University
Sports Medicine
Attn: BJ Ercolino or Brandon Mitchell
Indoor Sports Complex
100 Nicolls Rd.
Stony Brook, NY 11794-3500

Phone: (631) 632-7124 – BJ Ercolino
Phone: (631) 632-7709 – Brandon Mitchell
Fax: (631) 632-3231


Thank you for your cooperation. Go Seawolves!

# ATHLETIC INSURANCE QUESTIONNAIRE 2010-2011

Practice and competition will not be permitted until an athletic insurance questionnaire is completed in its entirety.

**Please Print – no pencil, pen only. All blanks must be completed, including signatures.**

Athlete's name: ________________________________________ Sport: ______________________________

Home address: ________________________________________ ID#:______-______-______ YR: FR SO JR SR SR+

City: ________________________________________ State: _______________ Zip: ________________

Phone #'s: Cell: _____-_____-_______ Campus: _____-_____-_______ Home: _____-_____-_______

Birthdate: ______/______/_______ Age: ________ Email:_____________________________________

Emergency Contact : ________________________________ Relationship: __________________________________

Home Phone: _____-_____-_______ Work Phone: _____-_____-_______ Cell Phone: _____-_____-_______

**Father's/Guardian's Information**

Name: ____________________________________

Date of Birth:_____________________________

Home Address: ____________________________

__________________________________________

Home Phone: ______________________________

Work Phone: ______________________________

Cell Phone: _______________________________

Employer: _________________________________

**Mother's/Guardian's Information**

Name:_____________________________________

Date of Birth:______________________________

Home Address: _____________________________

__________________________________________

Home Phone: _______________________________

Work Phone: _______________________________

Cell Phone: ________________________________

Employer: _________________________________

**My Medical Insurance is through my……_____Father _____Mother _____Spouse _____Self**

**My Dental Insurance is through my……_____Father _____Mother _____Spouse _____Self**

Is the plan an **HMO/PPO/POS?** *Health*: _____ yes _____ no *Dental*: _____ yes _____ no

| Medical Insurance: | | Dental Insurance: |
|---|---|---|
| ____________________________________ | Insurance company | ____________________________________ |
| ____________________________________ | Address | ____________________________________ |
| ____________________________________ | Policy # | ____________________________________ |
| ____________________________________ | Group # | ____________________________________ |
| ____________________________________ | Member # | ____________________________________ |
| ____________________________________ | ID # | ____________________________________ |
| ____________________________________ | Telephone # | ____________________________________ |

Do you have any other *Medical* insurance? _____ No _____ Yes Any other *Dental* insurance? _____ No _____ Yes

If yes, please attach another completed form with the same information as in sections 3 and 4.

## PLEASE READ AND SIGN OTHER SIDE!

Please attach any information, which will need to be followed in regards to your primary carrier in case any medical treatment or procedures are needed. A letter detailing the Stony Brook University's policy will be sent to each parent or guardian and is available on the Sports Medicine page at www.goseawolves.org. I, ______________________________, hereby authorize Stony Brook University and their insurance carrier/claims administrator to inspect or secure copies of case history records, laboratory reports, diagnosis, x-rays, and any other data covering this and/or previous confinements and/or disabilities. I authorize Stony Brook University and their insurance carrier/claims administrator to pay the medical vendors directly for any bills incurred from accidents that are covered under the coverage purchased by the Stony Brook University. Should the coverage have a deductible, my insurance payments will be credited towards the deductible.

The information I have provided is correct to the best of my knowledge. And I understand the information provided to me.

______________________________________________ ______/_______/_______

**Signature of Student-Athlete** **Date**

______________________________________________ ______/_______/_______

**Signature of Parent/Guardian (MANDATORY!)** **Date**

**Additional Comments/Information:** ______________________________________________

______________________________________________________________________________

**Please fill out your current campus address in the space below:**

Campus Address: ______________________________________________

City: ______________________________ State: NY Zip: __________________

****Please Attach Copies of Insurance cards below for both Medical Insurance (Required) And Dental Insurance (if available)****

| **MEDICAL Front** | **MEDICAL Back** |
|---|---|
| **DENTAL Front** | **DENTAL Back** |

**Please return (hand deliver or mail) as soon as possible to:**

**Kathryn A. Koshansky**
**Assistant Athletic Director for Sports Medicine**
**Athletic Department**
**Stony Brook University**
**Stony Brook, NY 11794-3500**
**Phone 631-632-7217**

Sports Medicine Staff only:
Initial: _________

Date: _________