

PLEASE RETURN TO ATHLETIC TRAINING ROOM

The following information and authorization must be completed, signed, and returned before the athlete will be allowed to participate!

Athlete's Full Name _____	Sport _____
Athlete's Social Security Number _____	Birthdate _____
Permanent Address (City/State/Zip) _____	Phone () _____

PRIMARY INSURANCE:

Policy Holder _____ Relationship _____

Policy Holder's Social Security Number _____ Policy Holder's Date of Birth _____

Policy Holder's Home Address _____

Home Telephone Number () _____ Work Telephone Number () _____

Policy Holder's Employer's Name _____

Employer's Address _____

Name of Insurance Company _____ ID Number _____

Insurance Mailing Address _____ Group Number _____

Insurance Company Telephone Number () _____

Is your dependent son/daughter covered under the above policy? Yes No. Is this an HMO or PPO?

Does your insurance require: a second opinion for surgery? Yes No Pre-authorization for service? Yes No

SECONDARY INSURANCE:

Policy Holder _____ Relationship _____

Policy Holder's Social Security Number _____ Policy Holder's Date of Birth _____

Policy Holder's Home Address _____

Home Telephone Number () _____ Work Telephone Number () _____

Policy Holder's Employer's Name _____

Employer's Address _____

Name of Insurance Company _____ ID Number _____

Insurance Mailing Address _____ Group Number _____

Insurance Company Telephone Number () _____

Is your dependent son/daughter covered under the above policy? Yes No. Is this an HMO or PPO?

Does your insurance require: a second opinion for surgery? Yes No Pre-authorization for service? Yes No

I HAVE NO INSURANCE.

Please indicate which of the following medical facilities in the Fargo-Moorhead area your insurance company will allow you to use. If your insurance company allows you to receive services anywhere, MeritCare Clinics and Hospital will be used since our Team Physicians are affiliated with MeritCare.

PLEASE CHECK ALL THAT APPLY:

My insurance allows for services **ANYWHERE** in the Fargo/Moorhead area

- MeritCare** Hospital
- MeritCare** Clinics:
 - Main Clinic (Fargo)
 - Moorhead Clinic
 - Satellite (specify) _____

- Innovis** Health
- Independent Physician** (specify) _____

Please Note:

You may want to consider transferring your medical insurance coverage to the Fargo/Moorhead area while you are participating in intercollegiate athletics. If you are from out-of-town, many HMO's or PPO's will only cover medical expenses within your local region. This often becomes inconvenient for the student-athlete when he/she has to travel to hometown hospitals or clinics.

Authorization, Agreement, Consent, Release and Indemnification

I hereby authorize Minnesota State University Moorhead to inspect or secure copies of case history records, laboratory reports, diagnoses, x-rays and/or any other data covering this and/or previous confinements and/or disabilities.

I understand the risks of injuries and losses that can occur as a result of participating in intercollegiate athletic activities and assume all such risks. I hereby allow Minnesota State University Moorhead's Athletic Medical Staff to administer whatever medical treatment and/or care deemed necessary for the health and well-being of myself. Furthermore, I consent to have administered to me any emergency medical or surgical treatment recommended by any licensed physician. In consideration of the student athlete being permitted to participate in Minnesota State University Moorhead's Intercollegiate Athletic Program, I release and agree to indemnify and hold harmless Minnesota State University Moorhead, its Board, president, officers and employees against and from any and all claims, damages and expenses arising out of or resulting from such injuries, losses and medical treatment or care. A photostatic copy of this authorization shall be deemed as effective and valid as the original.

Date: _____ Signature of Custodial Parent/Legal Guardian _____
(if athlete is under 18 years of age)

Date: _____ Signature of Student-Athlete _____

Please submit a photocopy of your insurance card to accompany this form.

We must have copies of **BOTH** sides of the card.

You will not be allowed to participate without a copy of your card on file!