

LOS RIOS COMMUNITY COLLEGE DISTRICT

ATHLETIC ACCIDENT INSURANCE INFORMATION

EACH ATHLETE MUST FILL OUT AND SIGN INSURANCE VERIFICATION FORM  
PARENT SIGNATURE IS ALSO REQUIRED

REPORT AN INJURY: Accident insurance information is necessary to expedite payment of all claims incurred in injuries in Inter-Collegiate Sports. When an injury occurs, immediately inform the coach and the trainer even though it may be minor at the time. The coach and the trainer must obtain the details of the accident for the reporting required by Los Rios Community College District, and will direct the student for medical evaluation and care if it is deemed necessary.

PAYMENT FOR MEDICAL CARE OF INJURIES: You or your legal guardian are responsible for payment of medical treatment if not paid by insurance. Your parental or personal insurance carrier (*including Kaiser*) will be the primary source of payment for any injuries incurred in Inter-Collegiate sports or college activity and should be billed accordingly by the doctor/hospital for services rendered.

It is your personal responsibility to inform the doctor/hospital at the time of treatment of your parental or personal insurance carrier.

The Los Rios Inter-Collegiate Athletic Insurance is the excess carrier if you have personal coverage.

This insurance plan assists in protecting Inter-Collegiate athletics if they are injured while participating in or being transported under the sponsorship of the college Inter-Collegiate athletic program. The coverage encompasses practice sessions, athletic contests, and college supervised travel to and from athletic events. **Athletes transporting themselves or being transported by individuals not employed by the college are excluded from coverage.**

The policy has a **\$100 deductible** per injury. Therefore, the participant injured will be responsible for the first \$100 of any claim submitted. Some medical costs may not be covered by insurance.

In the event of injury/illness that occurs during participation in athletic events, practice or while being transported to or from the site of the contest, I/We the undersigned consent to any diagnostic, medical, or surgical treatment deemed advisable by the attending licensed physician.

I/We have read the insurance information statement for the coverage of Student-Athletes of the Los Rios Community College District and understand that the policy is designed to pay most, but may not pay all, of the medical expenses of the participant injured under the conditions mentioned in the attached letter. Check with the Health Office for information on limitations. We understand any injuries sustained must be reported to the College Athletic Trainer as soon as possible, and failure to do so may void college responsibility.

FOR COVERAGE BY THE LOS RIOS INTER-COLLEGIATE ATHLETIC INSURANCE: COPIES OF ALL BILLS, AS THEY ARE RECEIVED, MUST BE SUBMITTED TO THE HEALTH CENTER.

Date: \_\_\_\_\_

Student's Signature \_\_\_\_\_

Parent's Signature \_\_\_\_\_  
(For Student-Athletes under 18 years of age)

**(Please complete Verification of Insurance on the back of this form)**



# LOS RIOS COMMUNITY COLLEGE DISTRICT

## VERIFICATION OF INSURANCE

ARC   
 CRC   
 FLC   
 SCC

**PLEASE ANSWER ALL QUESTIONS. IF FORM IS NOT COMPLETE, BENEFIT CONSIDERATION CANNOT BE MADE ON YOUR CLAIM.**

<b>1.</b>	CLAIMANT'S NAME	BIRTHDATE / /	AGE	SOCIAL SECURITY NUMBER - -
HOME ADDRESS (STREET) (CITY) (STATE) (ZIP)			HOME TELEPHONE NUMBER ( )	
ARE YOU EMPLOYED? <input type="checkbox"/> YES <input type="checkbox"/> FULL TIME <input type="checkbox"/> PART TIME <input type="checkbox"/> NO		MARITAL STATUS <input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED		(If you are not employed, but are covered under your own insurance, please fill in the information below.) (If married or divorced please complete Section 2)
IF EMPLOYED, PLEASE COMPLETE THE FOLLOWING:	EMPLOYER'S NAME		EMPLOYER TELEPHONE NUMBER ( )	
EMPLOYER'S ADDRESS (STREET) (CITY) (STATE) (ZIP)				
INSURANCE COMPANY (NAME AND ADDRESS)				
MEMBER, POLICY NUMBER				
<b>2.</b>	SPOUSE'S NAME			SOCIAL SECURITY NUMBER - -
IS YOUR SPOUSE EMPLOYED? <input type="checkbox"/> YES <input type="checkbox"/> NO (If yes, please complete the following):		SPOUSE'S EMPLOYER'S NAME		TELEPHONE NUMBER ( )
EMPLOYER'S ADDRESS (STREET) (CITY) (STATE) (ZIP)				
SPOUSE'S INSURANCE COMPANY NAME AND ADDRESS				
IS STUDENT COVERED BY THIS POLICY? <input type="checkbox"/> YES <input type="checkbox"/> NO		IS THIS A HMO/PPO PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO		SPOUSE'S MEMBER, POLICY NUMBER
<b>3.</b>	FATHER'S NAME			SOCIAL SECURITY NUMBER - -
FATHER'S HOME ADDRESS				HOME TELEPHONE NUMBER ( )
IS YOUR FATHER EMPLOYED? <input type="checkbox"/> YES <input type="checkbox"/> NO (If yes, please complete the following):		FATHER'S EMPLOYER'S NAME		TELEPHONE NUMBER ( )
FATHER'S EMPLOYER'S ADDRESS (STREET) (CITY) (STATE) (ZIP)				
FATHER'S INSURANCE COMPANY NAME AND ADDRESS				
IS STUDENT COVERED BY THIS POLICY? <input type="checkbox"/> YES <input type="checkbox"/> NO		IS THIS A HMO/PPO PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO		FATHER'S MEMBER, POLICY NUMBER
<b>4.</b>	MOTHER'S NAME			SOCIAL SECURITY NUMBER - -
MOTHER'S HOME ADDRESS				HOME TELEPHONE NUMBER ( )
IS YOUR MOTHER EMPLOYED? <input type="checkbox"/> YES <input type="checkbox"/> NO (If yes, please complete the following):		MOTHER'S EMPLOYER'S NAME		TELEPHONE NUMBER ( )
MOTHER'S EMPLOYER'S ADDRESS (STREET) (CITY) (STATE) (ZIP)				
MOTHER'S INSURANCE COMPANY NAME AND ADDRESS				
IS STUDENT COVERED BY THIS POLICY? <input type="checkbox"/> YES <input type="checkbox"/> NO		IS THIS A HMO/PPO PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO		MOTHER'S MEMBER, POLICY NUMBER

I understand that any person who knowingly and with intent to defraud any insurance company of other person files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning facts, material thereto, commits a fraudulent act, which is a crime.

SIGNATURE	DATE
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