POLICY & PROCEDURE -- ATHLETIC INJURY

1. Each year the athlete is required to have a complete physical before he/she may practice or participate in athletic events. Students are also required to provide insurance information and sign an Assumption of Risk form. The completed Risk forms are kept on file in Student Services office. The complete Insurance Information forms are kept in the Student Health Office as well as in the Athletic Trainer’s office.

2. The student should take a copy of the ‘INSURANCE INFORMATION’ form to the facility where injury treatment is being administered. Student Health personnel/Athletic Trainer will make copies for the athletes to take to the health care provider.

3. When an athletic injury occurs, the athlete should be evaluated by the Athletic Trainer. If the injury occurs outside of Student Health hours and requires immediate attention, the student should be seen by appropriate personnel. If Student Health/Athletic Trainer is not consulted for the injury, then an Injury Report must be completed by the Coach and returned to Student Health within 48 hours. This is especially important when the injury occurs out of town. The following information should be included on the Injury Report:
   A. Name
   B. Date of injury
   C. Place of injury – (practice or game) (in town or out of town)
   D. Actual Injury
   E. Where referred – Physician, Emergency Room, etc.
   F. Also provide any bills (if applicable)

4. Following is the process for filing claims regarding insurance:
   a. If the athlete is covered under parents’ insurance, then the claim is first sent to their primary insurance carrier.
   b. Whatever part of the claim is not paid by the primary insurance should be sent to the College for further processing.
   c. The College has a deductible for each injury. If this has not been met, the College is responsible for payment of the claim up to the deductible. After the deductible has been met, the College secondary insurance will pay according to the policy.
   d. Parents are responsible for providing information on their primary insurance and any changes in their insurance coverage! When you receive a bill, please send it to the Student Health office AS SOON AS POSSIBLE.
   e. When an athlete requires prescription medication, the athlete will need to pay the bill and then bring the receipt to Student Health. Once the receipt is received, then a claim is filed with the College insurance. If the deductible has been met, then the insurance carrier will issue a check repaying the athlete. If the deductible has not been met, then the College is responsible and will issue a check to the student. Refills are handled in the same way.
   f. Payment of claims can be a long process. Athletes and parents should be aware that the claims may not be paid immediately but will eventually be taken care of.
   g. It is to everyone’s benefit for the athlete or Coach to provide insurance information to the health-care facility when the injury occurs. Also remember to tell the facility that the College is the secondary carrier. This will expedite payment.

If an athlete or parent has any questions on this process, please contact Student Health or the Athletic Department.

ASSUMPTION OF RISK

I know there are special benefits from the experiences and activities of student athletes in the intercollegiate athletic program at Colby Community College. I specifically understand that student athletes are exposed to the danger and risk of physical injury. Participation in the intercollegiate athletic program may result in mild, moderate or severe injury to muscles, tendons, ligaments, bone, skin, teeth or any of the vital organs. In addition, catastrophic injury, permanent paralysis and even death may occur. There is no absolute method to prevent injury. I understand that a student athlete must share responsibility for his or her own safety and the safety of others.

By signing below, I acknowledge that I have read this risk statement. I am fully and completely aware of all risks associated with my participation in intercollegiate athletics and do hereby assume the risk of same. And allow Colby CC to communicate with my parents about any insurance claims and injuries that occur due to participation in intercollegiate athletics.

I HAVE READ AND UNDERSTAND THE ABOVE POLICIES AS WRITTEN. FAILURE TO COMPLY WITH THIS POLICY MAY RESULT IN MY BEING RESPONSIBLE FOR MY SON/DAUGHTER’S ATHLETIC INJURY CLAIMS.
(After both parent and student have signed, return to C.C.C. Athletic Office prior to the start of practice.)

Name of Student-Athlete (Printed) ___________________________ Sport(s) ___________________________

Signature of Student-Athlete ___________________________ Date ___________________________

Signature of Parent ___________________________ Date ___________________________

(7-14)
Dear Parent:

Our athletic accident policy which provides insurance for your son or daughter for injuries occurring while participating in the play or practice of intercollegiate sports is “EXCESS” or “SECONDARY” to any other collectible primary insurance benefits. This simply means that any claim for benefits must first be filed with the primary insurance company providing coverage to your son or daughter through your family primary insurance. After they have paid all available benefits, our athletic insurance company will pay any remaining amounts.

**WE, AS THE COLLEGE, DO NOT HAVE THE OPTION OF WAIVING THE REQUIREMENT OF FILING WITH YOUR FAMILY INSURANCE. A COPY OF YOUR INSURANCE CARD IS REQUIRED TO BE SUBMITTED WITH THE REQUIRED DOCUMENTS.**

**PLEASE NOTE:**
1. Most primary health insurance allows dependent coverage to be continued to age 23 if the dependent is a full-time student. DO NOT drop dependent coverage while your son or daughter is participating in intercollegiate athletics.
2. By utilizing both your primary insurance and our athletic insurance, all bills will be paid in full. You will not be required to pay your insurance deductible or any coinsurance amounts. Please provide a photocopy of your insurance card or other proof of insurance.

**THE FOLLOWING INFORMATION AND AUTHORIZATION MUST BE FULLY COMPLETED, SIGNED AND RETURNED TO COLBY COMMUNITY COLLEGE ATHLETIC DEPARTMENT.**

Parent’s Email________________________

Father’s Name_____________________________________________________________ Social Security #_________________________ DOB:_________________

Home Address___________________________________________________________________________ (Street) (City, State, & Zip Code)

Employer’s Name_________________________________________________________ Employer’s Address___________________________________________________________________________ (Street) (City, State, & Zip Code)

Home Phone #___________________________ Cell Phone#___________________________ Work Telephone#__________________

Mother’s Name_____________________________________________________________ Social Security #_________________________ DOB:_________________

Home Address___________________________________________________________________________ (Street) (City, State, & Zip Code)

Employer’s Name_________________________________________________________ Employer’s Address___________________________________________________________________________ (Street) (City, State, & Zip Code)

Home Phone #___________________________ Cell Phone#___________________________ Work Telephone#__________________

**POLICY YOUR DEPENDENT SON/DAUGHTER IS COVERED UNDER.**

Name of Primary Insured___________________________________________________________

Name of Insurance Co.__________________________________________ Policy #_________________________ Group #_________________________

Mailing Address for Claims_________________________________________________________________________ (Street) (City, State, & Zip Code) (Telephone #)

Does your insurance require:  
A second opinion for surgery?    YES    __    NO  
Pre-authorization for services?    YES    __    NO

________________________ I hereby authorize a claim to be filed on my behalf under the above medical insurance policy in the event an athletic injury is sustained by ____________________________.

________________________ My son/daughter is NOT covered under my health insurance.

**PLEASE ENCLOSE A COPY (FRONT & BACK) OF THE INSURANCE CARD COVERING YOUR SON/DAUGHTER.**

I hereby certify that the answers provided are true, complete and correct to the best of my knowledge. A photo copy of this authorization shall be considered as effective and valid as the original. Further, I acknowledge that I have received, read, understand and agree to follow the Colby Community College Athletic Department’s Policies and Procedures on Injuries and Physicals. I understand that, if I do not follow the procedures, expenses may not be covered by the Colby Community College insurance carrier.

Date_________________________ Signature of Parent__________________________