

2013-14 INDIVIDUAL ATHLETIC ACCIDENT INSURANCE PLAN ENROLLMENT FORM

Every full-time student athlete who participates in intercollegiate athletics and does not provide evidence of primary medical insurance that covers intercollegiate sports injuries will be automatically enrolled in this Athletic Accident Plan. This plan only provides a \$5,000 Maximum Benefit Limit per Accident. A premium of \$650 will be billed to your school account.

INSTITUTION NAME: Carthage College

ATHLETE'S NAME (Please Print): _____

Athlete's Street Address: _____

City: _____ State: _____ Zip _____

Athlete's Date of Birth: _____/_____/_____ (MONTH/DAY/YEAR)

Athlete's Student ID Number: _____

Athlete's Daytime Phone Number: (_____)_____

Student's Email Address: _____





Intercollegiate Sport(s) I participate in: _____

IMPORTANT: This completed form must be submitted to your Athletic Trainer prior to participation in any practice or play of an intercollegiate sport. Coverage starts on the date the signed application is received by EIIA, the insurance administrator for your school.

I hereby certify that as a full-time student athlete as named above, the information contained on this enrollment form is true. I understand that the effective date of coverage is the date enrolled in this coverage. There will be no refunds after September 15, 2013. Refunds prior to September 15, 2013 will be considered if you provide proof of primary insurance coverage to your Athletic Trainer and have not filed an eligible claim under this policy. I acknowledge that I have received and read the 2013-14 Individual Athletic Accident Insurance Plan document.

Athlete's Signature: _____ Date: _____

 **Detach and Retain for Your Records**
(please fill in your name and ID # below)

<p>2013-2014 Identification Card United States Fire Insurance Company</p> <p>Student Athlete Name: _____</p> <p>Student ID#: _____</p> <p>The Student Athlete whose name appears above is insured under an Individual Athletic Insurance Policy issued to:</p> <p>Institution: Carthage College Policy Number: US096803</p> <p> Interplan Health Group® A HealthSmart Network</p>	<p>CLAIM FILING INSTRUCTIONS</p> <p>Initial medical treatment must be received by a doctor within 90 days after the date of the accident causing injury or onset of sickness. Claims must be submitted to NAHGA Claim Services within 6 months after the date of injury. Mail all medical bills including the insured student's name, student ID number, address and name of the institution that the student attends to:</p> <p>NAHGA Claim Services, PO Box 189, Bridgton, ME 04009 Phone: 877.497.4980 Fax: 207.647.4569</p> <p>NOTICE TO HEALTH CARE PROVIDERS: For information regarding plan benefits, eligibility or claim instructions please call NAHGA Claim Services at 877-497-4980. <u>This card is not a guarantee of payment or coverage.</u></p> <p>  </p> <p>Available network outside the primary PPO service area</p>
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