

## **TO: PARENTS OF ST. ANDREWS INTERCOLLEGIATE ATHLETES**

We are extremely pleased to have your son/daughter as a student athlete at St. Andrews and hope that he/she will achieve academic, social, and athletic success.

Each student athlete is required to have a physical examination prior to any participation in any intercollegiate sport. The final decision on physical qualifications or reason for rejection is the responsibility of the team physician or athletic director. The team physician or athletic trainer also makes the decision on when an athlete may return to competition after a previous injury.

### **INJURIES----MEDICAL BILLS----INSURANCE COVERAGE----CLAIM PROCEDURE**

Accidents do occur and we attempt to provide our athletes with the very best possible care. Medical bills may be incurred when the athlete is treated for bodily injury due to an accident, whether it be locally, during a road trip, or by a medical vendor in his/her own home area.

#### **ONE FIRM STATEMENT:**

The NCAA discourages any college or university from providing coverage or paying the bills incurred for expenses related to illnesses or conditions which are not sustained as the direct result of an accident in our intercollegiate sports program. (This includes pre-existing conditions and non-athletic injuries.)

#### **INSURANCE COVERAGE:**

The athletic accident insurance at St. Andrews provides coverage for your son/daughter for accidents while participating in the play or official team practice of intercollegiate sports, including sponsored and authorized team travel.

#### **CLAIM PROCEDURE:**

All medical bills for your son/daughter incurred as the result of an accident in the intercollegiate sports program will be sent directly to your son/daughter or to your home address, unless the college or university has instructed the medical vendors otherwise. In some cases the athletic department may get a copy of the bill, but in no case will the athletic department be the primary place for the bill incurred to be sent.

- A. Submit the bills incurred to your family, employer group coverage or plan first. They will do one of two things:
  1. Honor the claim and pay all or a portion of the bills incurred.
  2. Not honor the claim and send you a letter of denial. An example might be that your son/daughter is no longer part of your group policy after attaining the age of twenty-three.
- B. If there remains a balance after your family, employer group insurance or plan has contributed towards the claim, send the claim sheet from the insurance company and a copy of the itemized bills incurred to the college or university's athletic department.

If you receive a letter of denial from your family, employer group insurance or plan administrator, then send the letter of denial and a copy of the bills incurred to the college or university's athletic department. If no coverage is available, a letter from your employer with verification will be necessary.
- C. If the bills incurred and not paid by the family, employer group insurance or plan is large enough, the claim will be sent from the athletic department to our insurance carrier office, which is in Kalamazoo, Michigan for processing. If they need any additional information, please cooperate with them and they will process the claim in the least possible amount of time. It is in your best interest to have the claim settled promptly since all the bills incurred are in your name.

**PLEASE NOTE:** If the primary family coverage is through an HMO (Health Maintenance Organization) or PPO (Preferred Provider Organization) you must follow the proper procedures required by your plan in order for the college's insurance to satisfactorily complete its portion of the claim. This is especially important if your plan requires pre authorization to have your son/daughter treated if out of your plan's service area.

Parents should retain this letter for future references. In addition, we ask that you complete the attached form **IN DETAIL** and return to us prior to any athletic participation. Your cooperation in this important area will help make this program successful in minimizing delays and accomplishing the purpose for which it is intended.



**First Agency, Inc.**  
 5071 West H Avenue  
 Kalamazoo, MI 49009-8501

**PARENT/GUARDIAN/STUDENT INFORMATION FORM**

**RETURN FORM WHEN COMPLETE TO** → Name of College/University St Andrew's Presbyterian College  
 Attention Athletic Training Department  
**This form is to be completed by the** Address 1700 Dogwood Mile  
**Parents, Guardians or Student** City Laurinburg State NC Zip 28352

**Note: Complete all blanks on this form. Failure to complete all blanks will result in claims processing delays.**  
 If information is not applicable, indicate the reason it is not (e.g., deceased, divorced, unknown).

Name of Athlete \_\_\_\_\_ Sport \_\_\_\_\_  
 Social Security No or Passport No \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 College Address \_\_\_\_\_ College Phone (\_\_\_\_) \_\_\_\_\_  
 Home Address \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

FATHER/GUARDIAN INFORMATION	MOTHER/GUARDIAN INFORMATION
Father's Name _____	Mother's Name _____
Social Security No. _____	Social Security No. _____
Date of Birth _____	Date of Birth _____
Address _____	Address _____
Employer _____	Employer _____
Address _____	Address _____
Telephone (____) _____	Telephone (____) _____
Medical Insurance Company or Plan _____	Medical Insurance Company or Plan _____
Address _____	Address _____
Policy Number _____	Policy Number _____
Telephone (____) _____	Telephone (____) _____
Is this plan an HMO or PPO? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is this plan an HMO or PPO? <input type="checkbox"/> Yes <input type="checkbox"/> No
Is pre-authorization required to obtain treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is pre-authorization required to obtain treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No
Is a second opinion required before surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is a second opinion required before surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No



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### **AUTHORIZATION - To Permit Use and Disclosure of Health Information**

This Authorization was prepared by First Agency, Inc. for purposes of obtaining information necessary to process a claim for benefits.

Upon presentation of the original or a photocopy of this signed Authorization, I authorize, without restriction (except psychotherapy notes), any licensed physician, medical professional, hospital or other medical-care institution, insurance support organization, pharmacy, governmental agency, insurance company, group policyholder, employer or benefit plan administrator to provide First Agency, Inc. or an agent, attorney, consumer reporting agency or independent administrator, acting on its behalf, all information concerning advice, care or treatment provided the patient, employee or deceased named below, including all information relating to, mental illness, use of drugs or use of alcohol. This Authorization also includes information provided to our health division for underwriting or claim servicing and information provided to any affiliated insurance company on previous applications. If this Authorization is for someone other than myself, that individual has given me the authority to act on his/her behalf as explained below.

I understand that I have the right to revoke this Authorization, in writing, at any time by sending written notification to my agent or to us at the above address. I understand that a revocation will not be effective to the extent we have relied on the use or disclosure of the protected health information or if my Authorization was obtained as a condition to determine my eligibility for benefits. Revocation requests must be sent in writing to the attention of the Claims Supervisor.

I understand that First Agency, Inc. may condition payment of a claim upon my signing this authorization, if the disclosure of information is necessary to determine the level or validity of the claim payment. I also understand, once information is disclosed to us pursuant to this Authorization, the information will remain protected by First Agency, Inc. in accordance with federal or state law.

I understand that I or my authorized representative is entitled to receive a copy of this authorization upon request.

This Authorization is valid from the date signed for the duration of the claim.

\_\_\_\_\_  
Name of Claimant (please print)

\_\_\_\_\_  
Name of Authorized Representative, or Next of Kin (please print)

\_\_\_\_\_  
Signature of Claimant (if claimant is 18 or older)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Authorized Representative of Next of Kin

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship of Authorized Representative or Next of Kin to Claimant

## St. Andrews Athletic Department

### Student-Athlete Nutritional Supplement Disclosure and Review Form

I, \_\_\_\_\_, am taking or intend to take the following nutritional

Please print name

supplements. I acknowledge the risk of losing my eligibility to participate in intercollegiate athletics if I test positive for an NCAA banned substance that may be found in a substance that I may take, regardless of the reason or purpose for taking such supplements. I also acknowledge the possible health risks that may be associated with taking an over the counter nutritional supplement.

I acknowledge and understand the labeling on these products can be misleading and inaccurate because they are not regulated by the Food and Drug Administration (FDA). Sales personnel are paid to sell these products and cannot accurately certify that these products contain no substances banned by the NCAA. Terms such as “healthy” or “naturally occurring” do not necessarily mean safe to take or use, or the NCAA endorses a product or approves its use. In another words, what’s in the bottle is not always on the label. If I do not know what I am taking, I am risking both my health and my eligibility.

The NCAA does not does not accept ignorance as an excuse following a positive drug test for a banned substance. Before taking or using any supplement, I am responsible for taking appropriate steps to ensure that it does not contain any substance banned by the NCAA. By making this disclosure, I am requesting that these products and their ingredients be reviewed by our institution’s head athletic trainer for the purpose of determining whether they are medically safe to use and do not contain substances banned by the NCAA. I do not hold the institution’s head athletic trainer responsible if I decide to take a supplement, I understand the risk of testing positive by taking the supplement. I understand that I should not take or use these products until their usage has been approved by my institution’s head athletic trainer.

Brand Name	Listed Ingredients	Banned Substances
1. _____	_____	_____
	_____	_____
2. _____	_____	_____
	_____	_____
3. _____	_____	_____
	_____	_____
	_____	_____

\_\_\_\_\_  
Signature of Student Athlete

\_\_\_\_\_  
Signature of Head Athletic Trainer