

**STUDENT ACCIDENT
INTERCOLLEGIATE SPORTS QUESTIONNAIRE**

Name: _____ Title: _____
 Telephone No: _____ Fax No: _____
 Name of School: _____
 Association: _____ Division: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Athletic Website: _____ E-mail: _____

SECTION I SPORTS CENSUS:

If the school participates in any of the following intercollegiate sports, please specify the number of participants in each sport.

	Intercollegiate			Intercollegiate	
	M	F		M	F
Band	_____	_____	Ice Hockey	_____	_____
Baseball	_____	_____	Lacrosse	_____	_____
Basketball	_____	_____	Rugby	_____	_____
Boxing	_____	_____	Soccer	_____	_____
Cheerleading	_____	_____	Softball	_____	_____
Crew	_____	_____	Swimming	_____	_____
Cross Country	_____	_____	Tennis	_____	_____
Diving	_____	_____	Track & Field	_____	_____
Equestrian	_____	_____	Volleyball	_____	_____
Field Hockey	_____	_____	Wrestling	_____	_____
Flag/ Touch FB	_____	_____			
Football	_____	_____	Coaches/ Managers	_____	_____
Golf	_____	_____	Other	_____	_____
Gymnastics	_____	_____			

SECTION II GENERAL INFORMATION:

Are student athletes required to have a medical exam before participating in intercollegiate sports? Yes No
 Are student athletes required to have a medical exam before returning to sports after an injury? Yes No
 Are student athletes required to certify the presence of or lack of personal health insurance prior to participating in intercollegiate sports? Yes No
 What is the estimated percentage of uninsured athletes? _____ %
 Is there a certified athletic trainer on your staff? Yes No
 If yes, how many? FT _____ PT _____
 Do you currently have pre-paid arrangements with any medical providers for intercollegiate sports injuries:
 On staff? Yes No (please describe) _____

On retainer? Yes No (please describe) _____

For discounted services? Yes No (please describe) _____

Other? (please describe) _____

When a deductible or other out-of-pocket expenses exist after payment by the current sports policy, how is the deductible satisfied?

College pays:

Student pays

Other; Explain: _____

Student Accident/Health policy pays:

SECTION III EXPERIENCE INFORMATION:

Summarize your policy experience for the current policy year, and 3 prior years. Attach insurance company loss runs.

	Current Year	Year 20__	Year 20__	Year 20__
Premium Paid	\$	\$	\$	\$
Number of Claims paid as of (date) _____				
Amount of claims paid as of (date) _____	\$	\$	\$	\$
Number of claims paid in excess of \$10,000				
Number of claims pending as of (date) _____				
Amount of claims pending as of (date) _____	\$	\$	\$	\$
How were medical benefits paid? (Check one in each column) E = Excess P = Primary	<input type="radio"/> E <input type="radio"/> P	<input type="radio"/> E <input type="radio"/> P	<input type="radio"/> E <input type="radio"/> P	<input type="radio"/> E <input type="radio"/> P
Accident Medical Limit	\$	\$	\$	\$
Accidental Death Limit	\$	\$	\$	\$
Aggregate Limit of Indemnity	\$	\$	\$	\$
Accident Medical Deductible	\$	\$	\$	\$
Benefit Period (Check one in each column) 52 weeks, 104 weeks, 158 weeks	<input type="radio"/> 52 <input type="radio"/> 104 <input type="radio"/> 156	<input type="radio"/> 52 <input type="radio"/> 104 <input type="radio"/> 156	<input type="radio"/> 52 <input type="radio"/> 104 <input type="radio"/> 156	<input type="radio"/> 52 <input type="radio"/> 104 <input type="radio"/> 156
Did policy contain expanded medical coverage for aggravation, re-injuries, overuse, etc.	<input type="radio"/> YES <input type="radio"/> NO	<input type="radio"/> YES <input type="radio"/> NO	<input type="radio"/> YES <input type="radio"/> NO	<input type="radio"/> YES <input type="radio"/> NO
Did policy contain coverage for expenses incurred as a result of the insured's going out of their HMO/ PPO network.	<input type="radio"/> YES <input type="radio"/> NO	<input type="radio"/> YES <input type="radio"/> NO	<input type="radio"/> YES <input type="radio"/> NO	<input type="radio"/> YES <input type="radio"/> NO
Heart / Circulatory Coverage	<input type="radio"/> YES <input type="radio"/> NO	<input type="radio"/> YES <input type="radio"/> NO	<input type="radio"/> YES <input type="radio"/> NO	<input type="radio"/> YES <input type="radio"/> NO
List the sports which were added or dropped for each policy year listed.				
Insurance Carrier Name				
Insurance Agent				

What is the current premium payment plan? _____

SECTION IV BENEFIT SELECTION:

What benefit levels would you like us to consider for quoting purposes?

Accident Medical Limit \$25,000 \$50,000 \$75,000 Other: _____

Accidental Death and Dismemberment Limit None \$ 1,000 \$5,000

Accident Medical Deductible \$ _____ Per cause Annual Aggregate

Proposed Policy Effective Date: _____ Date Proposal Requested By: _____

Signature _____ Date _____