



September 2015

MEMO TO: Parents/Guardians of Student Athletes

FROM: Karen Ware, Assistant to the Chair, and  
Insurance Coordinator

RE: Accident Insurance for Club Sports Injuries

As your student begins his/her sport season, it is important that the Athletic Department obtain information for our athletic insurance carrier. It is required that each club sport participant's information be submitted each year regardless of whether or not there are any changes.

Club Sport athletes are covered by a secondary insurance policy purchased by Williams College to **SUPPLEMENT** your own medical insurance coverage. The policy will only pay for services **NOT** paid or payable by the student's primary health insurance. Athletes involved in in-season practice, games, and specific travel as a group representing Williams College are covered by this policy. Any out of season club sport related activities will not be covered by this policy. The policy is administered by NACDA Insurance and has a \$1,000 deductible, which means that you are required to show proof of payment of the first \$1,000 of expenses before the supplemental insurance begins. Our athletic insurance covers accidental bodily injury and chronic over-use types of injuries sustained as a result of practice or play in a covered activity. Coverage for all bills **must** first be filed with and processed by your primary personal insurance before being filed with NACDA insurance program.

Timely communication with Health Services about the injury and bills resulting from treatment is critical because of the following requirements of the policy:

- 1) The club sport athlete must be seen at Health Services regardless of where the injury occurred to ensure documentation of the injury. Proof of Loss and HIPAA disclosure forms will be issued at that time.
- 2) Within 30 days after a covered loss occurs or begins, or as soon as is reasonably possible, notice of claim must be made.

- 3) The athlete must incur a medical expense for treatment of the covered accident within 90 days from the date of accident.
- 4) This policy will pay for medically necessary covered expenses up to 2 years from the date of accident.
- 5) UB92's and HCFA forms (medical provider's standard billing forms) must be submitted when filing with NACDA insurance. **Request these forms at the time of services.**
- 6) Do not pay medical bills up front or in advance. Pricing agreements maybe in place between the provider and the insurance company which you will not be able to factor. Any difference between insurance payments and billed charges will be your responsibility.
- 7) Keep in mind, if your child is out of network, you should coordinate with your insurance company before services are rendered to get the best coverage possible. In the event of a claim, you will need to **immediately** contact NACDA Insurance to review the claim procedures. **Our contact person is Libby Keuffel her phone number is 801-412-2629, the address is 2180 South 1300 East, Suite 520, Salt Lake City, UT 84106.**

Please complete the enclosed Parent's Insurance Form and return it to me as soon as possible at the following address:

Thank you.

Karen Ware, Assistant to the Chair and  
Insurance Coordinator  
Williams College Athletics  
22 Spring Street  
Williamstown, MA 01267

Enc.

Athlete's Name \_\_\_\_\_ SS# (this will be required at time of claim filing).

Sport CLUB School \_\_\_\_\_

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 group insurance benefits. This means that any claim for benefits must first be filed with the group insurance company providing coverage to your son or daughter through your employer or your spouse's employer. After they have paid all available benefits, our athletic insurance company will consider remaining amounts based on USUAL and CUSTOMARY charges.

WE, AS THE SCHOOL, DO NOT HAVE THE OPTION OF WAIVING THE REQUIREMENT OF FILING WITH YOUR GROUP INSURANCE.

PLEASE NOTE:

- 1. Most employer's group insurance allows dependent coverage to be continued to age 25 if the dependent is a full-time student. DO NOT drop dependent coverage while your son or daughter is participating in intercollegiate athletics.
- 2. Claims against your group insurance plan DO NOT increase your individual insurance premiums.

THE FOLLOWING INFORMATION AND AUTHORIZATION MUST BE FULLY COMPLETED, SIGNED AND RETURNED; please circle the individual listed as the insured on your primary/personal plan and complete all requested information.

Father/Guardian/Spouse/Self (circle one) Date of Birth \_\_\_\_\_

Name \_\_\_\_\_ Social Security # This will be required at time of claim filing

Home Address \_\_\_\_\_  
(Street) (City, State & Zip Code)

Employer's Name \_\_\_\_\_

Employer's Address \_\_\_\_\_  
(Street) (City, State & Zip Code)

Home Telephone # \_\_\_\_\_ Work Telephone # \_\_\_\_\_

Name of Group Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Policy # \_\_\_\_\_

Mailing Address for Claims \_\_\_\_\_ Telephone # \_\_\_\_\_  
(Street) (City, State & Zip Code)

IS YOUR DEPENDENT SON/DAUGHTER COVERED UNDER THE ABOVE POLICY? YES \_\_\_\_\_ NO \_\_\_\_\_

Does your insurance require: A second opinion for surgery? YES \_\_\_\_\_ NO \_\_\_\_\_ Is your primary insurance an HMO? YES \_\_\_\_\_ NO \_\_\_\_\_

Pre-authorization for services? YES \_\_\_\_\_ NO \_\_\_\_\_ Is your primary insurance a PPO? YES \_\_\_\_\_ NO \_\_\_\_\_

Mother/Guardian/Spouse/Self (circle one) Date of Birth \_\_\_\_\_

Name \_\_\_\_\_ Social Security # This will be required at time of claim filing

Home Address \_\_\_\_\_  
(Street) (City, State & Zip Code)

Employer's Name \_\_\_\_\_

Employer's Address \_\_\_\_\_  
(Street) (City, State & Zip Code)

Home Telephone # \_\_\_\_\_ Work Telephone # \_\_\_\_\_

Name of Group Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Policy # \_\_\_\_\_

Mailing Address for Claims \_\_\_\_\_ Telephone # \_\_\_\_\_  
(Street) (City, State & Zip Code)

IS YOUR DEPENDENT SON/DAUGHTER COVERED UNDER THE ABOVE POLICY? YES \_\_\_\_\_ NO \_\_\_\_\_

Does your insurance require: A second opinion for surgery? YES \_\_\_\_\_ NO \_\_\_\_\_ Is your primary insurance an HMO? YES \_\_\_\_\_ NO \_\_\_\_\_

Pre-authorization for services? YES \_\_\_\_\_ NO \_\_\_\_\_ Is your primary insurance a PPO? YES \_\_\_\_\_ NO \_\_\_\_\_

I hereby authorize a claim to be filed on my behalf under the above group medical policy in the event an athletic injury is sustained by \_\_\_\_\_

My son/daughter is NOT covered under my group insurance.

I hereby certify that the answers provided are true, complete and correct to the best of my knowledge. I authorize release of the above insurance information to any concerned providers. A photostatic copy of this authorization shall be considered as effective and valid as the original.

Date \_\_\_\_\_ Signature of Parent \_\_\_\_\_