Consolidated Health Plans

SPORTS SUBMISSION

NAME OF INSTITUTION: ____

ADDRESS: ____

CITY: ______________________________ STATE: _________ ZIP: _______________

CONTACT PERSON: ______________________ TITLE: ________________________

PHONE: _________________________ FAX: _______________________

E-MAIL: ____

AGENT: __________________________________ COMMISSIONS: _____________

CONTACT: ____

CURRENT CARRIER: ____

EFFECTIVE DATE: ______________ SPORT SANCTIONING BODY & DIV.: __________

BENEFIT PLAN SUMMARY
(Describe below or attach Schedule of Benefits)

	2015-2016	2014-2015	2013-2014	2012-2013	2011-2012
Plan Maximum					
Benefit Period					
Treatment Window					
Policy Term Dates					
Deductible					
Dental coverage					
AD&D Coverage					
Excess or Primary					
HMO/PPO Denial					
Expanded Medical					
Re-Injury/Re-Agg.					
Heart/Circulatory					
Pre-Existing Cond.					
Guest/Recruit Cov.					

PREMIUM AND LOSS HISTORY

YEAR	INSURANCE CARRIER	GROSS PREMIUM PAID	# OF CLAIMS PAID	TOTAL AMOUNT OF CLAIMS PAID	AS OF DATE*
2015-2016					
2014-2015					
2013-2014					
2012-2013					
2011-2012					

***As of Date must be within 3 months of submission date.**

Risk Management Information:

Certified athletic trainer(s) on staff? ❑ Yes ❑ No

If yes, for which sports is trainer responsible? ____________________

____

Team Physician: ❑ On Staff ❑ On Retainer ❑ Other (Please describe) ____________________

____

Physician's Specialty:____________________

Is physician board certified? ❑ Yes ❑ No

Does the athletic department or coaching staff routinely:

Obtain information about athlete's other insurance coverage? ❑ Yes ❑ No

Require pre-participation physical examination? ❑ Yes ❑ No

If yes, for which sports? ____________________

____

Type of institution? ❑ Public ❑ Private

Type of surface where activities take place? ❑ Artificial ❑ Grass

What other activities take place on this surface? ____________________

____

Does your institution have a medical school which provides care at no cost to the athletes? ❑ Yes ❑ No

What percentage of your student athletes have primary medical coverage? ____________________

Please include Carrier detailed loss reports, to include high dollar claims which exceed $10,000.

SPORTS ADDITIONS/DELETIONS WHICH HAVE OCCURRED DURING THE RECENT (5) YEAR PERIOD – PLEASE LIST CHANGES AND YEAR OF OCCURRENCE:

____

____

BENEFIT CHANGES REQUESTED BY SCHOOL – PLEASE LIST CHANGES:

____

____

This is not an offer of coverage nor an application for insurance. Requests for coverage will be subject to company underwriting standards. Actual coverage terms will be described in a policy of insurance if one is issued.

I understand that the insurance company in determining whether to provide a quotation for insurance coverage will rely on the information contained in the form and all other information being submitted. I hereby warrant, represent and confirm that, to the best of my knowledge, all information provided is complete, true and correct.

____________________ ____________________

Applicant's Signature Producer's Signature (if applicable)

____________________ ____________________

Applicant's Name (print) Producer's Name (print)

____________________ ____________________

Date (MM/DD/YY) Date (MM/DD/YY)

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