

**St. Cloud State University  
Emergency Contact and Insurance Information 2009-10**

The Acknowledgement of Insurance Requirements must be read, understood, signed, and this form completed and on file with St. Cloud State University **PRIOR** to the student-athlete participating in practice and/or competition. **All sports must have forms on file by August 1, 2009.**

**Please return to Julie Alexander, ATC, 720 4<sup>th</sup> Ave. So., HaH 304, St. Cloud, MN 56301-4498  
or fax to 320-308-2099, attn. Athletic Training.**

Athlete Name \_\_\_\_\_ Sport \_\_\_\_\_  
Policy Holder Name \_\_\_\_\_ Policy Holder Date of Birth \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State/Zip \_\_\_\_\_  
Email \_\_\_\_\_ Home phone \_\_\_\_\_  
Work phone \_\_\_\_\_ Cell phone \_\_\_\_\_  
Insurance Company Name \_\_\_\_\_  
Insurance Company Address \_\_\_\_\_  
ID or Policy # \_\_\_\_\_ Group# \_\_\_\_\_  
Does this policy cover athletically-related injuries? YES \_\_\_\_\_ NO \_\_\_\_\_  
Does this policy require primary physician referral for visits in St. Cloud? YES \_\_\_\_\_ NO \_\_\_\_\_

**Acknowledgement of Insurance Requirements**

I, \_\_\_\_\_, as parent/guardian or legal representative, attest that  
(name, please print)  
\_\_\_\_\_ has insurance coverage under a current, in force insurance  
(student-athlete name, please print)  
policy for injuries that occur while he/she/I is/am participating in intercollegiate athletics.

**If there is a change in coverage or expiration of coverage, I agree to notify St. Cloud State University of the development and update the insurance information I have on file with the Athletic Training staff in a timely manner.**

I understand that St. Cloud State University is a secondary insurance holder and that the student-athlete/I must have primary insurance coverage to compete on any of the intercollegiate teams supported by the St. Cloud State University Athletic Department.

\_\_\_\_\_  
(policy holder signature)

\_\_\_\_\_  
(date)