

**Kentucky Community and Technical College System
Excess Insurance for Camps/Conferences/Field Trips**

SUMMARY OF COVERAGE

Insurance Carrier: AXIS Insurance Company

Coverage: Insurance coverage is on an **excess** basis only. The participants' personal health insurance policy will be primary and provide coverage for accident. The **excess** policy will cover any out-of-pocket expense not paid by the participants' personal insurance up to the limits of the policy listed below. (This includes payment of the deductible and co-insurance amounts if applied under the participants' personal policy.) The benefit period is one year. The first expense must be incurred within 90 days of the accident. If the participant does not have personal health insurance coverage, this **excess** policy will pay first dollar, up to the limits of this policy. Sickness is not covered. Also, pre-existing conditions are not covered. A pre-existing condition is any condition for which a prudent person should have sought treatment or was treated in the previous six months.

Coverage Benefits and Limits:	Accident Medical Expense (Excess)	\$25,000
	Deductible	Nil
	AD&D and Paralysis, Principal Sum	\$15,000
	Benefit Period	One Year
	Effective Date	7/1/18
	Expiration Date	7/1/19

CONSENT TO MEDICAL TREATMENT/INSURANCE STATEMENT

It is understood that authority given to the Kentucky Community and Technical College System, or anyone they may designate, to have my son/daughter treated for injuries or illness he/she incurs during a designated camp, conference, or field trip activity with KCTCS.

I understand that I will be notified if a health problem arises, but in the event I cannot be reached by telephone, I hereby give KCTCS, or anyone they may designate, permission to seek medical treatment for the participant named below, including surgery (on an emergency basis) or additional advanced treatments (MRI, lab tests, etc.) as deemed necessary by competent medical personnel.

I am aware that, as the adult participant, or as the parent or legal guardian of the participant named below, I will be responsible for any expenses incurred outside of the limits provided by the Kentucky Community and Technical College System's Camps/Conference/Field Trip Policy. I also understand that KCTCS insurance coverage is on an "excess" basis only. The excess policy will cover any out-of-pocket expense not paid by the participant's personal insurance up to the limits of the policy listed above.

_____	_____	_____
Date	Name of Participant	Signature (Parent/Guardian if claimant is a minor)
_____	_____	_____
Emergency Contact (if other than parent)		Phone

MEDICAL AUTHORIZATION

Authorization to Release Information: I authorize any Health Care Provider, Insurance Company, Employer, Person or Organization to release any information regarding medical, dental, mental, alcohol or drug abuse history, treatment or benefits payable, including disability or employment-related information concerning the patient, to any CIGNA company, the Plan administrator or their employees and authorized agents for the purpose of validating and determining benefits payable. This data may be extracted for use in audit or statistical purposes. I understand that I or my authorized representative will receive a copy of this authorization upon request. This authorization or a photostatic copy of the original shall be valid for the duration of the claim.

_____	_____	_____
Signature (Parent/Guardian if claimant is a minor)	Date	Phone

Payment Authorization: I authorize all current and future medical benefits, for services rendered and billed as a result of this claim, to be made payable to the physicians and providers indicated on the invoices.

_____	_____
Signature (Parent/Guardian if claimant is a minor)	Date

**Kentucky Community and Technical College System
Camps/Conferences/Field Trips**

MEDICAL INSURANCE INFORMATION FORM

Participant Name: _____

_____ Last First Middle

Address: _____

_____ Street Apt. #

_____ City State ZIP Code

Participant's Social Security Number: _____

Age: _____ Date of Birth: _____

Parent/Guardian Name(s): _____

Business Phone: Mother _____ Step Mother _____

Father _____ Step Father _____

Cell Phone: Mother _____ Step Mother _____

Father _____ Step Father _____

Home Phone: Mother _____ Step Mother _____

Father _____ Step Father _____

Neighbor or Relative (other than Parent/Guardian): _____ Phone: _____

Primary Insurance Information

Parent's Insurance Covering Participant

Insured: _____ Date of Birth: _____

Policy Number: _____ Member ID #: _____

Insurance Co.: _____ Phone #: _____

Insurance Co. Address: _____

Second Parent's Insurance (if participant is also covered under this policy)

Insured: _____ Date of Birth: _____

Policy Number: _____ Member ID #: _____

Insurance Co.: _____ Phone #: _____

Insurance Co. Address: _____

**You must submit a copy of the front and back of all insurance and
Rx identification cards covering participants. Thank you!**

Check and sign if participant has no health coverage.

There is no health insurance coverage for this participant at this time.

Signature (Parent/Guardian if claimant is a minor)

Date

HEALTH CONDITIONS AND ALLERGIES Please check here if student has no health conditions or food allergies.

Health Conditions: _____

Allergies: Latex Eggs Other, please specify _____

PHOTO RELEASE As a parent or guardian, I give my permission for my son or daughter's image to be used in Hopkinsville Community College and Kentucky Community and Technical College System materials, including but not limited to publications, video, marketing materials and advertisements used to promote the colleges of KCTCS.

Parent/Guardian Name

Signature