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 coinsurance 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)\$25,000DeductibleNilAD&D and Paralysis, Principal Sum\$15,000Benefit PeriodOne YearEffective Date7/1/13

Expiration Date

Consent to Medical Treatment/Insurance Statement

7/1/14

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 this claim, to be made payable to the physicians and proven the physicians and proven the physicians are proven to the physicians	•	
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:				
Address:	Last	First	Middle	
7 da1033	Street		Apt. #	
	City	State	ZIP Code	
Participant's Social	Security Number:			
Age:	Date of Birth:			
Parent/Guardian Na	ame(s):			
Business Phone:	Mother	Step Mo	other	
	Father	Step Fa	ther	
Cell Phone:	Mother	Step Mo	other	
	Father	Step Fa	ther	
Home Phone:	Mother	Step Mo	other	
	Father	Step Fa	ther	
Neighbor or Relativ	ve (other than Parent/Guardian):	Pho	one:	
	Primary II	nsurance Information		
Parent's Insurance	e Covering Participant			
Insured:	o covering randopant	Date of Birth:		
Policy Number:		Marshar ID #		
Insurance Co.:				
	ress:			
Second Parent's I	nsurance (if participant is also co	vered under this policy)		
Insured:		Date of Birth:		
Policy Number:		Member ID #:		
Insurance Co.:		Phone #:	_ Phone #:	
Insurance Co. Addı	ress:			
		the front and back of all insura		
	Check and sign if par	rticipant has no health coveraç	ge.	
☐ There is no	health insurance coverage for this p	participant at this time.		
Signature (Parent/C	Guardian if claimant is a minor)	 Date		
HEALTH CONDITI	ONS OR FOOD ALLERGIES			
Hopkinsville Comm	EAs a parent or guardian, I give my pounity College and Kentucky Communers, video, marketing materials and a	inity and Technical College Syste	em materials, including but not	
Parent/Guardian Name		 Signature		