



Office of Sports Medicine

ATHLETIC RELATED MEDICAL BILLS LETTER OF RESPONSIBILITY

We, _____ and _____,
(Student-Athlete) (Insurance Policy Holder-ie. Parent, Guardian)

hereby understand that there may be medical bills resulting from an injury/illness incurred while participating as a member of Kutztown University's Intercollegiate Athletics Program. I/We acknowledge that I/we am responsible for any and all medical bills. I/We also agree to the following:

A. I/we understand that I/student-athlete must be covered by a Primary Health Insurance policy that covers Intercollegiate related athletic injuries and I am/we are responsible for providing proof of that primary policy to the KU Office of Sports Medicine and notifying them if there is/are any change(s) in that policy.

Government-funded insurance plans (such as Tricare, Medicaid, etc.) are NOT considered primary medical insurance. If a student-athlete has a government-funded insurance plan, the student-athlete may sign a waiver to decline the secondary medical insurance provided by Kutztown University. Please contact the Director of Sports Medicine via email at sacco@kutztown.edu or at (484) 646-4287 regarding this option.

B. I/we have read the "Policies and Procedures Regarding Athletic Participation, Injuries, Illnesses and Medical Care" document and fully understand its content.

C. I/we understand that Kutztown University Student Services, Inc. (KUSSI) has a Supplemental Accident Insurance plan and that plan has a \$1,500 Deductible per Injury Claim, which I/we or my/our 'Primary' insurance plan will be responsible for satisfying before using the KUSSI Supplemental plan.

D. I/we understand that for an athletically related injury/illness to be eligible for coverage under the KUSSI Supplemental Athletic Accident Insurance, I/the student-athlete MUST report the injury/illness to the Sports Medicine Staff within 30 days of its onset.

E. I/we understand that Kutztown University's Office of Sports Medicine will assist me/us in filing injury claims but has no liability for the accuracy or payment of the claims.

F. I/we further understand that the Commonwealth of Pennsylvania, Kutztown University, KUSSI and/or any University employee is in no way liable for payment of any medical bills.

G. I/we accept the responsibility of ensuring any insurance claims are submitted correctly and in a timely manner. I/we also accept that it is my/our responsibility to follow up on medical claims with both the medical providers and insurance companies involved with any bills.

H. I/we understand that there is a limitation on the time in which medical bills must be submitted to my/our insurance company(ies) and failure to address any medical bills within that time could affect my credit record and also result in the denial from the KUSSI Supplemental Athletic Accident Insurance.

I. I/we understand that all Intercollegiate Athletic related medical services by "Outside Physician/Specialist": 1) MUST follow my Primary Health Insurance process; 2) MUST be done "In-Network"; and 3) MUST be approved in writing by a member of the Sports Medicine staff, to be considered for secondary payment thru KUSSI insurance program.

J. I understand that any costs associated with the failure to follow the above will be my responsibility alone.

Student Full Name (PRINT) Birth Date Sport
Student Signature Date
Policy Holder Full Name (PRINT)
Policy Holder Signature Date