

DIOCESE OF PITTSBURGH
PROTECTED INSURANCE PLAN

REQUEST FOR MEDICAL COVERAGE INFORMATION
FORM *A"

Participating Student _____

Mother's Name _____ S.S. # _____

Father's Name _____ S. S.# _____

Mother's Employer's
Employer: _____ Address: _____

Phone: _____

Father's Employer's
Employer: _____ Address: _____

Phone: _____

Hospitalization Blue Blue Major Group # _____
Covering Athlete: Cross _____ Shield _____ Medical _____ I. D. No. _____

Other Policy I. D.
Coverage: _____ Number _____ Number _____

Proof of medical coverage is required for an athlete to participate in sports. If no coverage exists, the student CAN NOT participate in athletics.

A parent permitting a student to participate in school athletics after coverage has terminated or without coverage will assume full responsibility for any medical claim resulting from an injury while participating in the sport.

It must be understood that coverage for injury resulting from athletic participation is specifically excluded from the Diocesan Insurance Programs. It is for this reason that the preceding paragraphs must be strictly adhered to.

I/We, the undersigned, do attest to the accuracy of the information provided on this form. Furthermore, should there be a change, the school principal, and coach will be notified immediately of any change.

Parent or Guardian's Signature

Approved: _____
(Principal)

Parent or Guardian's Signature

(Form Effective 07/01/94)
(PHOTOCOPY THIS FORX AS NEEDED)