Subject: POLICY COVERING PARTICIPATION IN ATHLETICS

The Diocesan Insurance Manual provides general information on coverage under the Diocesan Self-Insurance Program. More specific details are required for persons concerned with athletic programs and athletes.

The following is additional information on athletic program participation. Under the Diocesan Self-Insurance Program, injuries resulting from athletic participation are specifically excluded. Individuals participate in athletics at their own risk, with parents and/or guardians, if minor is injured, assuming responsibilities related thereto.

Furthermore, certain requirements of the School Office must be met before an individual can participate in Athletic Programs. They are as follows:

1. Physician medical release must be executed
2. Parents release must be executed
3. Hospitalization information must be furnished

A sample of the form has been included (Form A, attached), which incorporates necessary releases requested above. Permission to Participate forms are available through the Schools Office on the Diocese. After the forms have been executed by all the parties they should be retained in the local Schools Office for ready reference.

In the event of an athletic injury, A Report of Accident Form (Form B, attached) should be filled out and forwarded immediately to the Bureau of Insurance. Please note that preparation of this accident form in connection with Athletic Injury is not to be construed as an agreement on the part of the Diocese to make reimbursements regarding any medical expenses that may be involved. It is merely a report form satisfying various requirements. The following limitations on reimbursement for medical expense apply:

1. Supplemental to individuals own basic and major medical coverage. Reimbursement of expense after all personal coverage is exhausted.

2. Maximum coverage on permanent teeth limited to $125.00 per tooth.

3. No payment for expenses beyond one year of accident.

4. Claims submitted are thoroughly investigated by Bureau of Insurance before any reimbursement is made.

5. Claim payments will be delayed until such time as all necessary data is at hand.

6. Supplemental payment limited to $1,000.00 for each athletic related injury.

You make whatever photocopies that are needed of Forms A and B. It is not necessary to request a supply from the Insurance or School's Office.

Copy of executed 'Form A' must be attached to report of accident form submitted for information purposes.

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: ______________________ Employer's Address: ______________________

____

Phone: ______________________ ______________________

Father's Employer: ______________________ Employer's Address: ______________________

____

Phone: ______________________ ______________________

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

Other Coverage ____________ Policy Number ____________ I.D. 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 FORM AS NEEDED)

FORM 'B": Report Of Accident/Sports Related Injury

To: Diocese of Pittsburgh, Insurance/Employee Benefits Office, 111 Boulevard of the Allies, Pittsburgh, PA 15222

Parish or Institution ______________________ Injured Person ______________________

Address ______________________ Address ______________________

City ______________________ City ______________________

Date of Accident __________ Place of Accident ______________________ Time ______ AM PM

Apparent Age ______ Social Security No. (Injured Party) ______________________

If Minor - Father's Name ______________________ Social Security No. ______________

Mother's Name ______________________ Social Security No. ______________

Where was Injured Person Taken? ______________________

Attended by Doctor ______________________ ______________________

Name Address

Detailed description of accident and nature and extent of injuries (if additional space needed, use other side)

____

____

Witnesses: Name and Address ______________________

Name and Address ______________________

Coverage for injury resulting from athletic participation is specifically excluded from the Diocesan Self Insurance Programs.

However, the Diocese will provide payment of up to $1,000 towards the balance of athletic injury medical costs in excess of an individuals own coverage (Hospitalization, DPA, Blue Cross, Blue Shield, Major Medical, etc.). This payment is subject to strict limitations and no claim will be considered without full information required. As in the past, expenses beyond one year of accident date are not eligible expenses.

Hospitalization Carried (check) Blue Cross ___ Blue Shield ___ Major Medical ____

Other Coverage ______________ Policy/Group No. ______________ Agreement No. __________

Injured Party (or Parent, if injured party is a student or minor) is employed by:

____

The information listed above is correct: ______________________

Signature of Injured Person or Signature or Parent, if Minor

This report prepared by ______________________ Position ______________________

Date ______________ Signature ______________________

ATTACH COPY OF PHYSICIAN RELEASE EXHIBIT "A" ALLPARTS (PIP 04/95)