



MY/OUR EMPLOYMENT GROUP/INSURANCE COMPANY IS (IF NONE, LIST FATHER'S, MOTHER'S, AND/OR GUARDIANS SOCIAL SECURITY NO.) ALSO PROVIDE POLICY NUMBER AND TELEPHONE NO. FOR VERIFICATION.

In executing the foregoing release, I/We acknowledge that: I/We understand any claims for injury arising out of my/our child's participation, must be reported to the team official within 30 days of injury; I/We understand the "proof of loss" forms must be completed in full and filed within 60 days of mailing; I/We understand any monies I/We paid to the team, does not constitute payment for insurance coverage; I/We do "indemnify" the Conference/League and the Insurance carrier should there be statement(s) by "anyone" that is in contradiction; I/We certify I/We received a copy of this "contract" and the "disclosure" information required; I/We have read and understand fully, the provisions of this contract/release/authorization and I/we have signed it voluntarily.

Further, I/We hereby grant authority to a qualified medical practitioner to render such medical treatment as said qualified medical practitioner deems necessary under the circumstances.

**PLEASE LIST ALL ALLERGIES:** \_\_\_\_\_

CANDIDATES FULL LEGAL NAME (FIRST-MIDDLE-LAST AS SHOWN ON BIRTH CERTIFICATE)		CANDIDATES SIGNATURE		DATE
FATHER'S SIGNATURE	DATE	MOTHER'S SIGNATURE	DATE	GUARDIAN'S SIGNATURE
				DATE

**NOTE:** If available, **BOTH PARENTS WILL SIGN – ONE MUST**, or **GUARDIAN** if **NO** parents available. Forged signatures may result in Board AND/OR Legal action.

**A. IMPORTANT NOTICE (State Required "Disclosure" statement; C.I.C. Section 10270.2)**

**THIS IS AN EXCESS PLAN** – The Medical Expense Benefit of the Plan (Program) is an **EXCESS** type benefit that picks up where the other coverage leaves off. If you have any other individual, franchise, blanket or group (except automobile medical payments insurance) coverage which provides benefits of services for, or by reason of, medical or dental care or treatment, then this Plan (Program) will pay only the medical expenses not provided or reimbursable under your other coverage subject to a **deductible of \$500.00**. The premium for this Plan (Program) has been reduced, taking this into account.

If you have any other coverage, you should first submit your claim under that coverage. You should submit a claim under this Plan (Program) only if you have no other coverage or if your other coverage does not fully provide or pay for your medical care or treatment. (Form 2449 Ed. 1-75)

**B.** The Conference/League group insurance is "**CORRIDOR EXCESS**" only. This means the Parents/Guardians **OWN INSURANCE MUST BE NOTIFIED OF THE INJURY**. If the Parents/Guardians have insurance **WITH PRE-PAID MEDICAL PLANS**, such as Kaiser, the injured person **MUST BE TAKEN TO THE PRE-PAID MEDICAL FACILITIES** for treatment.

**C.** If the Parents/Guardians of the injured person **DOES NOT HAVE PRIMARY INSURANCE**, the Conference/League group insurance may be used, **BUT THERE IS A DEDUCTIBLE FOR EACH INJURY**.

**D.** The Conference/League group insurance **PAYS ONLY TO THE HOSPITALS AND DOCTORS** by assignment; not to the Parents/Guardians. Payment on the Conference/League is made **ONLY AFTER THE INJURED IS RELEASED FROM ALL MEDICAL TREATMENT**.

**E. THE AUTHORIZED TEAM OFFICIAL** reports injuries on the Accident Claim Form given to the **PARENTS/GUARDIANS WHO MUST FILL OUT THE TEAM CLAIM REPORT FORM AND SUBMIT IT**.

**F. EXCLUSIONS AND LIMITATIONS APPLY.**

**G.** To obtain **FULL DETAILS OF THE COVERAGE** please email Kathy D'Amato of SGVJAAFC at [vp@kapmfg.com](mailto:vp@kapmfg.com)

**SECTION V CERTIFICATION BY AUTHORIZED TEAM OFFICIAL**

I, the undersigned, have approved the candidate listed in Section II to participate with the team, division and Conference/League listed in Section #1 for the current season of play. I certify the birth record furnished does correspond with the candidate's name and date of birth shown in Section II; if the name is different, substantiation in full was furnished. I certify I received the candidate's report of grades and a 2.0 or higher scholastic grade average for the school year ending in May/June of the current year was maintained; or the candidate falls in the category of exemption, as outlined in the Conference/League rules. I certify the Medical Examination Form, was completed by a qualified Medical Practitioner, as was the parent consent, release of medical authorization in Section IV prior to the candidate's participation in any manner with the team. I certify I have explained fully, to the candidate's parent(s)/guardian(s), the procedures that **MUST** be followed in reporting an injury, including but not limited to, the time limits for completion of all forms, the deductible amounts, limits of coverage, excess benefits and state required disclosure statement applicable to the group insurance. Further, I certify, a copy of this contract was furnished to the parent(s)/guardians(s) as applicable.

AUTHORIZED TEAM OFFICIAL'S SIGNATURE	DATE	ADDRESS VERIFIED <input type="checkbox"/> YES <input type="checkbox"/> NO	TITLE
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SUBMIT ORIGINAL DOCUMENT TO CONFERENCE

(2) COPIES – AD (1) & PARENTS (1)