

LEWISVILLE INDEPENDENT SCHOOL DISTRICT
THE COLONY HIGH SCHOOL
ATHLETIC DEPARTMENT

ACKNOWLEDGEMENT OF INSURANCE FORM

School _____ Sport _____

1. I understand that it is my responsibility to verify that the form is filled out and mailed promptly to the Student Insurance Company.
2. I understand that Lewisville I.S.D. is not responsible for filing this claim, nor for any medical bills. Our insurance company will be responsible for claims within the policy and plan limits, as long as the proper procedures were followed.
3. I understand that if my child is covered by another insurance that I must follow the proper steps outlined in that policy and that the schools insurance will be a secondary provider. The only exception to this stipulation is if you have CHIPS, Medicare, or another government sponsored insurance. In this instance our insurance will be the primary.
4. The claim form must be sent within ninety days of the date your received medical care.

Student Name _____

Parents Signature _____

Date _____