

**SAINT LOUIS UNIVERSITY SPORTS MEDICINE
Acknowledgement of Insurance Requirements**

I, _____, as parent, guardian or legal representative, attest that
(name, please print)

_____ has insurance coverage under a current, in force insurance
(student-athlete name)

policy for injuries that occur while he/she is participating in intercollegiate athletics. This coverage has limits of at least \$75,000.

If there is a material change in coverage or expiration of coverage, I agree to notify Saint Louis University of this development and update the insurance information I have on file with Saint Louis University.

I understand and agree that Saint Louis University will assume no responsibility whatsoever for the payment of, or authorization to pay, medical expenses if I/we fail to have this primary insurance coverage.

(signature)

(date)

**THIS FORM MUST BE SIGNED AND RETURNED TO THE SAINT LOUIS
DEPARTMENT OF ATHLETICS BY AUGUST 1st.**

Return to:

Saint Louis University
3330 Laclede Ave
St. Louis, MO 63103
Telephone: 314-977-3295
FAX: 314-977-3183

**YOU MUST INCLUDE A COPY (FRONT AND BACK) OF YOUR CURRENT
INSURANCE CARD AND THE COMPLETED EMERGENCY CONTACT AND
INSURANCE INFORMATION FORM.**