

NAME OF SCHOOL: _____ **HEALTH CENTER REFERRAL:** No Yes **IF YES, REFERRAL MUST BE ATTACHED**

POLICY NUMBER: _____ **REFERRAL GIVEN BY:** _____ **DATE:** _____

MAIL TO: United States Fire Insurance Company, Personal Insurance Administrators, Inc., P.O. Box 6040, Agoura Hills, CA 91376-6040, 1-800-468-4343

Name of Student _____ Student ID Number _____ S.S. Number _____ Date of Birth _____

Current Home Address _____
Number and Street _____ City _____ State _____ Zip Code _____ Phone Number _____

Name of Insured Dependent _____ Date of Birth _____
if applicable

Current Home Address _____
Number and Street _____ City _____ State _____ Zip Code _____

CLAIM WILL BE RETURNED IF THIS SECTION IS NOT FULLY COMPLETED

1. Date of injury or beginning of sickness _____ When was physician first consulted? _____

2. Nature of injury or sickness _____

3. If injury, describe how and where accident occurred _____

4. Did injury occur during practice or play of sports? No Yes

If yes, please check one of the following: Intramural/Club Name of Sport _____

Intercollegiate Signature of Athletic Trainer _____

Other _____

5. Have you suffered same or similar condition before? No Yes

If yes, and you were previously treated for it, dates treated: _____

Name and address of physician who treated you: _____

6. If hospitalized at that time, date confined to hospital: _____

Name and address of hospital: _____

7. Was the injury the result of a motor vehicle accident? No Yes

Do you have other insurance which covers your condition (group, individual, automobile, medical or liability)? No Yes

If yes, who is the Holder of Policy: Self Parent Spouse Give name of company _____

If covered under Parent's/Spouse's Insurance or if privately insured, please include the following information:

Policy No. _____ Group No. _____ Phone No. of Insurance Co. _____

Parent's/Spouse's Name (Holder of Policy) _____ S.S. No. _____

Employer's Name and Address _____

Have you been insured under another health insurance plan any time during the past 12-month period? No Yes

If yes, give name of company and attach a copy of your Certificate of Prior Coverage _____

Address: _____ Phone Number: _____

Policy Number: _____ Effective Date of Coverage: _____ Date Coverage Terminated: _____

**PAYMENT WILL BE MADE TO THE PROVIDER OF SERVICE (HOSPITAL, PHYSICIANS AND OTHERS),
UNLESS A PAID RECEIPT OR STATEMENT ACCOMPANIES THE BILL AT THE TIME THE CLAIM IS SUBMITTED.**

IMPORTANT: THIS FORM MUST BE COMPLETED AND RETURNED TO THE COMPANY WITHIN 90 DAYS FROM THE DATE OF TREATMENT ACCOMPANIED BY ALL BILLS INCURRED TO THAT DATE. PLEASE ATTACH ITEMIZED BILLS.

For your protection, State Law requires that the following appear on this form: "Any Person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison."

AUTHORIZATION: I hereby authorize United States Fire Insurance Company, or its representative, to inspect or secure copies of case history records, laboratory reports, diagnosis, prognosis, x-rays, and any other data covering this and/or previous confinements and/or disabilities. A photostatic copy of this authorization shall be deemed as effective and valid as the original.

I understand that I or my authorized representative is entitled to receive a copy of this authorization upon request.

SIGNATURE OF STUDENT _____ **DATE** _____