

When completed, return this form to the Plan Administrator:



COMMERCIAL TRAVELERS
COLLEGE CLAIM DEPARTMENT
70 GENESEE STREET
UTICA, NEW YORK 13502
1-800-756-3702

Please check the correct Underwriting Company:

- Commercial Travelers Mutual Insurance Company
- Companion Life Insurance Company
- Niagara Life and Health
- Security Mutual Life Insurance Company

IMPORTANT: Please attach itemized bills. This form **MUST** be completed in full and returned to the company **WITHIN 90 DAYS** from the date of treatment accompanied by all itemized bills received to date. Mail to the address shown on this form. Payments will be made to the service provider unless otherwise advised.

Notice: When we are the secondary plan, we do not pay until after the primary plan has paid its benefits if any. We will review Usual & Customary charges of each plan and allow the highest. Any amount paid by your primary plan for an eligible expense under our plan may satisfy all or a portion of our deductible.

CLAIM CANNOT BE PROCESSED WITHOUT THIS INFORMATION

College (or) University		<input type="checkbox"/> Domestic Student—Soc. Sec. #			
		<input type="checkbox"/> International Student—Student ID #			
Student's Name		Policy #	<input type="checkbox"/> Male	Date of Birth	
			<input type="checkbox"/> Female		
If Claim for Dependent Give Name and Relationship	Name	Relationship	<input type="checkbox"/> Male	Date of Birth	
			<input type="checkbox"/> Female		
Student Mailing Address	Street Address	City	State	Zip	Telephone ()

1. Date of injury (or) onset of sickness _____ When was physician first consulted? _____
 Nature of illness (or) injury _____
 If injury, (a) How and where did accident occur? _____

(b) Were you practicing or playing any intercollegiate (between rival colleges) sport at the time of the accident? Yes No
 Club Sport? Yes No If "Yes," name sport _____

(c) IF AN INTERCOLLEGIATE ACCIDENT, THIS FORM MUST BE SIGNED BY THE ATHLETIC DEPARTMENT
 I certify the above accident resulted from the supervised practice or play or travel to and from an intercollegiate sport.

Signature of Athletic Department Official _____ Title _____ Date _____

2. Were you treated and/or referred by the Student Health Service? Yes No If "Yes," date _____

3. Hospital (Give name, address and date of confinement) _____
 _____ From / / To / /

4. Give names, addresses and telephone numbers of all attending physicians _____
 _____ Phone _____

5. Give name, address and telephone number of usual family physician _____
 _____ Phone _____

6. Have you suffered same or similar condition in the past? Yes No If "Yes," and you were treated for it, please give name and address of the physician who treated you _____
 Dates treated _____
 If hospitalized at that time: Name of hospital _____
 Address _____ Dates Confined _____

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

8. Are you employed full-time? Yes No If yes, Employers Name _____
 Employers Address _____ Employers Phone Number _____

9. Father's Name _____ SS# _____ Father's Employer-Name _____ Address _____ Employer's Phone # _____

10. Mother's Name _____ SS# _____ Mother's Employer-Name _____ Address _____ Employer's Phone # _____

11. Spouse's Name _____ SS# _____ Spouse's Employer-Name _____ Address _____ Employer's Phone # _____

12. Do you, your spouse or your parents have other insurance or medical plan which covers this condition, either group, individual, automobile, medical or liability?
 Yes No If so, give name of Company: _____

I hereby authorize any physician, hospital, company, employer, or organization to release any information regarding the medical history, treatment, or benefits payable for this claim, to the Insurance Company checked above or its authorized benefit plan administrator. A photostatic copy of this authorization shall be as valid as the original. I also authorize the Insurance Company checked above or their representatives to pay all bills in connection with this claim directly to the doctor, hospital or any other persons rendering service, and such payment shall release the Insurance Company from liability as to amounts so paid.

FOR RESIDENTS OF ALL STATES OTHER THAN THOSE LISTED ON PAGE 2: Any person who knowingly, and with intent to defraud, injure or deceive any insurance company, files or causes to be filed, a claim for payment of a loss, containing any false or incomplete information commits a fraudulent insurance act that may be a crime and may subject such person to confinement in prison, fines and denial of benefits.

I hereby CERTIFY that I have read the answers to all parts of this form and to the best of my knowledge and belief the information is complete and correct as given herein.

Name of student _____ Date _____

Signature of claimant (parent or guardian if not adult) _____

Student's Address While at School _____
 Street City State Zip

Alaska: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Arizona: For your protection Arizona law requires the following statement to appear on this form: Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Arkansas or Louisiana, Maryland, Rhode Island, West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

California: For your protection California law requires the following to 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.

Colorado: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Delaware: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida and Idaho: WARNING: Any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.* *In Florida - Third Degree Felony

Indiana: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person, files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.

Maine: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and a denial of insurance benefits.

Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

Nevada: Any person who misrepresents or falsifies essential information requested on this form may, upon conviction, be subject to a fine and imprisonment under state or federal law, or both.

New Hampshire: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

New York: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Nevada: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under state or federal law, or both, and may be subject to civil penalties.

Ohio: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma: WARNING: Any person who knowingly and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Oregon: Any person who knowingly and with intent to defraud or solicit another to defraud an insurer: (1) by submitting an application, or (2) by filing a claim containing a false statement as to any material fact, may be violating state law.

Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Tennessee: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Texas: 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.

Virginia: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Washington: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.