

When completed, return this form to the Plan Administrator:



COMMERCIAL TRAVELERS
70 GENESEE STREET
COMMERCIAL TRAVELERS BUILDING
UTICA, NEW YORK 13502
1-800-756-3702

Please check the correct Underwriting Company:

- Commercial Travelers Mutual Insurance Company
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.

CLAIM CANNOT BE PROCESSED WITHOUT THIS INFORMATION

Form with fields for: College (or) University, Student's Name, Policy #, Date of Birth, If Claim for Dependent, Name, Relationship, Date of Birth, 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 ... sport at the time of the accident?
(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.

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 (in FL, a felony in the third degree), and in the state of New York, 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.

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