MAIL TO:
FIRST STUDENT
P.O. BOX 809067
DALLAS, TEXAS 75380-9067

CLAIM FORM

COMPLETE IN DETAIL
TO INSURE
PROMPT HANDLING

Coverage Verified

NOTICE: Anyone who knowingly misrepresents or falsifies essential information requested by this form may, upon conviction, be subject to fine or imprisonment.

❑ GRADUATE
❑ UNDERGRADUATE

-PLEASE PRINT ALL INFORMATION-

PART I - MUST BE COMPLETED BY STUDENT AND SIGNED

Name of College or University, City and State	Domestic ❑ International ❑	Student ID Number	Birth Date

Insured Student's Name _____
LAST NAME FIRST NAME M.I. SOCIAL SECURITY # PHONE #

❑ Present Address _____
Street Address

❑ Home Address _____
City State Zip

PLEASE MAIL ALL CORRESPONDENCE AND PAYMENTS TO THE ADDRESS ABOVE.

If claim for dependent, give dependent's name_____ Relationship to Insured _____ Age ____ Sex ____

MUST BE COMPLETED

Mother's Name _____ Employer _____
Name and Address of Insurance Co. _____ Policy No. _____
Father's Name _____ Employer _____
Name and Address of Insurance Co. _____ Policy No. _____
Spouse's Name _____ Employer _____
Name and Address of Insurance Co. _____ Policy No. _____
Are you covered (as an insured or dependent) by any other hospital and/or medical plan? ❑ Yes ❑ No
Have you filed a claim with any other insurance company? ❑ Yes ❑ No
Send copies of all Explanation of Benefits paid or denied to First Student at the above address.

1. Date of accident or sickness.		Date of first treatment
2. Indicate reason for medical treatment.		
3. If injury, describe how and when accident occurred and indicate if work related.		
4. If injured in play or practice of sport, indicate which sport.		Check One ❑ Intramural ❑ Intercollegiate ❑ Other ❑ Club
5. Have you previously been troubled with this condition?	❑ Yes ❑ No Date _____	
6. Were you seen or referred by the physician for this condition?	❑ Yes ❑ No Date _____	
7. Name and address of Provider, other than Student Health Service.		
8. Give names of all other physicians consulted.		
9. Hospitalized? If so where and what dates.	Where?	From:_____ ____ To: _____ ____

PAYMENT WILL BE MADE TO THE PROVIDERS OF SERVICE, UNLESS A PAID RECEIPT IS ATTACHED AT TIME OF SUBMISSION.

To any medical care provider, medical care facility, insurer, government-sponsored health plan, or employer: I authorize the release of any medical information about me to Student Insurance. This applies to all information about the diagnosis, treatment, or prognosis of any illness or injury I now have or have had in the past. The Company will use this information to determine if my claim is eligible. Any information obtained will not be released by the Company except to my primary health insurance carrier (if any) or persons or organizations performing investigative or legal services for the Company in connection with my claim. A copy of this authorization shall be considered as effective and valid as the original and shall remain in effect for one year from the date of authorization. I certify that the information given by me in support of my claim is true and correct.

Patient's or Authorized Representative's Signature _____ Date _____

If Authorized Representative, Relationship to Patient _____
or Legal Designation _____
STREET CITY STATE ZIP CODE + 4

ITEMIZED BILLS FOR MEDICAL EXPENSES MUST BE ATTACHED.

0000-CLM

PART II - ATTENDING PHYSICIAN STATEMENT
This Statement MUST Be Completed

AUTHORIZATION: I hereby authorize The Chesapeake Life Insurance Company, to inspect or secure copies of case history records, laboratory reports, diagnoses, prognoses, and any other data covering this or other confinements disabilities.

DOCTOR, PLEASE SIGN _____ DATE _____

EACH DOCTOR'S BILL ATTACHED NEEDS TO BE COMPLETED WHEN ITEMIZED WITH THE DOCTOR'S I.D. OR SOCIAL SECURITY NUMBER

Patient's name _____ **Date of Birth** _____

1. Nature of sickness or injury Describe any complications. (Include ICD-9)	
2. If fracture or dislocation, state whether reduced or immobilized. If fracture of long bones, state whether fracture is through shaft or extremity. Was it confirmed by X-Ray?	❑ No ❑ Yes
3. When did symptoms first appear or accident happen?	Date _____
4. When did patient first consult you for this condition?	Date _____
5. Has patient ever had same or similar condition? If yes, state when and describe.	❑ No ❑ Yes When? Date _____
6. Describe any other disease or infirmity affecting present condition.	
7. Nature of any surgical or obstetrical procedure. Describe fully. (Include CPT Code) Where and when performed?	Date _____ if in hospital, inpatient ❑ outpatient ❑
8. Give dates of treatment.	
9. Is condition a result of or in any way connected with pregnancy?	❑ No ❑ Yes Inception date of pregnancy _____
10. Is patient still under your care for this condition? If discharged, give date.	❑ No ❑ Yes When? Date _____
11. If patient hospitalized, give name and and address of hospital.	_____ Hospital City State Date admitted _____ Date discharged _____
12. Did you file this claim with any other Insurance Company? If yes, indicate the name and address of company.	❑ No ❑ Yes Name: _____ Address: _____

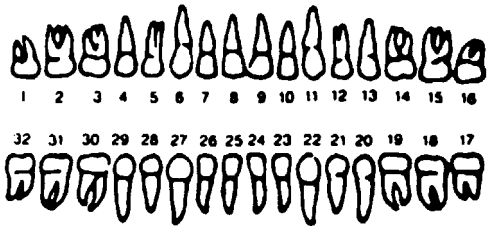
SIGNED: _____ DEGREE _____ DATE _____

I.D. or S.S. # _____ (THIS MUST BE INCLUDED!) PHONE# _____

ADDRESS: _____
STREET CITY STATE ZIP CODE + 4

IF DENTISTRY, ANSWER ALL QUESTIONS BELOW, IN ADDITION TO THOSE ABOVE.

1. State exactly which teeth were involved in the accident and indicate them on chart.
   _____
   _____
2. Describe exact nature of injury. _____
   _____
3. Describe condition of injured teeth prior to accident:
   ❑ Whole, sound and natural ❑ Filled ❑ Crowned ❑ Artificial
4. Comments: _____



IMPORTANT: This form MUST be completed and returned WITHIN 30 DAYS from the date of treatment accompanied by all bills incurred by that date.