

CLAIM FORM
SUBMIT CLAIMS TO: STUDENT INSURANCE DIVISION P.O. BOX 809025 DALLAS, TX 75380-9025

TO BE COMPLETED BY STUDENT

Student Identification

Student Name: _____ Male Female

SS# _____ Date of Birth _____ Marital Status: _____

Your Employer's Name & Address: _____ Phone: _____

Current Address: _____

Home Address: _____

Patient Identification:

Patient Name: _____ Male Female

Relationship to Student _____ Date of Birth _____ Marital Status _____

Claim Information:

Describe Sickness/Injury suffered: _____

Date Sickness began/Date time of Injury _____ Hour _____ AM PM

How did it occur?: _____ Where did it occur?: _____

Was the Injury/Sickness caused by: Patient's Employment Intercollegiate sports Neither

Medical History:

Name of first Doctor that treated you for this condition: _____

Address: _____ Phone: _____

Name of Family Doctor: _____

Address: _____ Phone: _____

Name, Address and Phone # of all doctors that treated you within the past 2 years:

Other Insurance Information:

Is the person for whom claim is being made insured under any other plan described below?

Your mother's or father's insurance?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Group insurance or any program of benefits or services for individuals as a group?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Blue Cross or Blue Shield or a Health Maintenance Organization (HMO)?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Any governmental program of benefits or services?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Any motor vehicle insurance coverage?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Any plan of benefits or services provided on an individual basis?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

If the answer to any of the above is "yes" complete the following:

Name of Policyholder	Policy No.	Name and address of Company providing benefits or services
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Please be sure to send copies of all bills to other Company and send us their explanation of benefits paid on your behalf.

TURN OVER

Enrollment Information (to determine eligibility for student insurance):

		Undergraduate	Graduate			Undergraduate	Graduate
Fall	_____ to _____ #Hrs _____	<input type="checkbox"/>	<input type="checkbox"/>	Fall	_____ to _____ #Hrs _____	<input type="checkbox"/>	<input type="checkbox"/>
	Mo/Yr Mo/Yr				Mo/Yr Mo/Yr		
Winter	_____ to _____ #Hrs _____	<input type="checkbox"/>	<input type="checkbox"/>	Winter	_____ to _____ #Hrs _____	<input type="checkbox"/>	<input type="checkbox"/>
	Mo/Yr Mo/Yr				Mo/Yr Mo/Yr		
Spring	_____ to _____ #Hrs _____	<input type="checkbox"/>	<input type="checkbox"/>	Spring	_____ to _____ #Hrs _____	<input type="checkbox"/>	<input type="checkbox"/>
	Mo/Yr Mo/Yr				Mo/Yr Mo/Yr		
Summer	_____ to _____ #Hrs _____	<input type="checkbox"/>	<input type="checkbox"/>	Summer	_____ to _____ #Hrs _____	<input type="checkbox"/>	<input type="checkbox"/>
	Mo/Yr Mo/Yr				Mo/Yr Mo/Yr		

Indicate dates & credit hours of enrollment in School for this and the prior year. Prior year information may not be needed. But, if it is necessary, obtaining it now will avoid further delay. If the medical expenses for this condition exceed or will exceed \$1,000, the above information must be certified by the Registrar or authorized school representative. See Policyholder section below.

To Be Completed by Policyholder

1. Verification of Eligibility for Student Insurance (Required only for claims over \$1,000):

Please verify all enrollment information given by the Student above. If the information is incorrect, enter the correct data and initial the change.

An authorized school representative must sign below and affix official school seal to verify enrollment information on all claims over \$1,000.

 Name & Title of authorized school representative (Please print) Signature of authorized school representative Date

Student Health Center Referral:

If your policy contains a Student Health Center (SHC) Referral Requirement, this section must be completed by SHC personnel.

The above student is being referred elsewhere for treatment because:

- Medically necessary services are not available at the health center facility.
- Other, Please indicate: _____

 Name of authorized SHC personnel (Please print) Signature of authorized SHC personnel Date

Authorization to Obtain Information

I authorize any physician, medical professional, hospital, clinic, medical care institution or medically related facility, insurance or reinsuring company, medical or hospital service or prepaid health plan, employer or group policyholder, contractholder, or benefit plan administrator to provide the Company and any benefit plan administrators, consumer reporting agencies, attorneys and independent claim administrators acting on the Company's behalf, with information concerning medical care, advice, diagnosis, treatment, prognosis, or supplies provided to the Patient, including information relating to mental illness, and any employment-related information regarding the Patient. Where applicable this is also to authorize my University to convey information to the Company regarding my eligibility as a student including the number of semester hours I am studying. I understand that this authorization shall be valid for the term of the Policy(ies). I agree that a photostatic copy of this authorization is as valid as the original.

I certify that the foregoing statements, including any accompanying statements are to the best of my knowledge and belief, true, correct, and complete. I will reimburse the Insurance Company for any overpayment made to me or in my behalf due to error on this form.

Patient's Signature: _____ Date: _____

Student's Signature: _____ Date: _____

CLAIM CANNOT BE PROCESSED WITHOUT YOUR SIGNATURE

I authorize payment directly to my medical provider(s) for charges incurred for this claim. If I have already made payment, I am enclosing paid receipts in which case I request reimbursement directly to me. I understand that I am financially responsible for all charges not covered by this authorization.

Student's Signature: _____ Date: _____

MAKE SURE FRONT SIDE IS ALSO COMPLETED