

When Completed, return this form to the Plan Administrator:

To locate the nearest MultiPlan Provider, contact:

Special Risk Claims
Commercial Travelers Mutual Insurance Co.
70 Genesee Street
Utica NY 13502, Toll Free: 800-756-3702



800-672-2140
www.multiplan.com

Underwriting Company: Companion Life Insurance Company, Columbia, SC

NOTIFICATION OF INJURY OR SICKNESS - STUDENT INSURANCE MEDICAL CLAIM FORM

(Please Print)

COLLEGE/UNIVERSITY: _____ POLICY NO: _____

Student Name: _____ Male Female

Social Security No.: _____ or Student ID No.: _____ Date of Birth: _____

Current Address: _____
(Street) (City) (State) (Zip Code)

If Claim is for Dependents:

Name of Dependent: _____ Relationship: _____

Male Female Date of Birth: _____ SSN: _____

Date of Injury (or) onset of Sickness: _____ When was physician First Consulted? _____

2. Nature of Injury (or) Illness: _____

3. If Injury, (a) how and where did accident occur? _____

(Please use back of Claim Form if Needed)

(b) Were you practicing or playing any intercollegiate (between rival colleges) sport at the time of the Accident? Yes No

If "Yes", name the Sport: _____ Approved by: _____
(Athletic Trainer or Director)

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

Referred by: _____
(College Physician or College Nurse)

5. **Have you suffered same or similar condition in the past?** Yes No **If "Yes", and if you were treated for it, please give name and address of the physician who treated you.**

Name: _____ Date Treated: _____

Address: _____

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

7. Was the injury or sickness a result of your employment? Yes No

8. a) Do you, your spouse or your parents have any other insurance or medical plan that covers this condition, either Group, Individual Automobile, Medical or Liability? Yes No

b) Please complete Page 2 of this form.

OTHER INSURANCE INFORMATION:

FATHER'S

NAME: _____

Social Security Number: _____ **Employed** Yes ____ No ____

Employer: _____

Address: _____

Phone Number: _____ **Contact Person:** _____

Does your father have group Medical Insurance coverage through his employment? Yes ____ No ____

Insurance Company: _____

Address: _____

Policy No.: _____

MOTHER'S NAME: _____

Social Security Number: _____ **Employed** Yes ____ No ____

Employer: _____

Address: _____

Phone Number: _____ **Contact Person:** _____

Does your mother have group Medical Insurance coverage through her employment? Yes ____ No ____

Insurance Company: _____

Address: _____

Policy No.: _____

TYPE OF PLAN:

____ Health Maintenance Organization (HMO) ____ Preferred Provider Organization (PPO) ____ Standard Med. & Hospitalization Coverage

____ Other (Describe): _____

If your mother or father have medical insurance coverage and your are not covered, or are partially covered, due to policy limitations, please explain: _____

If you have medical insurance coverage as an eligible dependent from a parents' previous marriage, as mandated in a divorce decree, please give details for filing a claim: _____

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 stated above or its authorized benefit Plan Administrator. A photocopy of this authorization shall be as valid as the original. I agree that all information provided in this document is accurate and complete to the best of my knowledge. I understand that any incorrect or undisclosed information can result in duplicate payments creating a substantial overpayment. Such overpayment will be the obligation of the undersigned, with responsibility to reimburse in full, upon request, all amounts deemed refundable. I also authorize the Insurance Company stated 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 intentionally includes false or misleading information in an attempt to defraud or deceive is guilty of a crime. 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.**

Signature: _____

Date: _____

(Please Print, Sign and Date Completed Claim Form)