

When completed, return this form to:

(For Athletic Claims)

(For All Other Claims)

To locate the nearest Beech Street Provider, contact:

Attn: Sports Medicine
Athletic/Rec Center
1009 Union Street
Valparaiso IN 46383
Phone: 219-464-5236 x3

Valparaiso University
Student Health Center
1406 LaPorte Ave.
Valparaiso IN 46383
Phone: 219-464-5060

or

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



___ Commercial Travelers Mutual Insurance Company

___ Security Mutual Life Insurance Company

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 Dependent:

Name of Dependent: _____

___ Male ___ Female Date of Birth: _____ Relationship: _____

1. 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 Cov.

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 checked above. 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 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 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: _____
(Please Print, Sign and Date Completed Claim Form)

Date: _____