When completed, return this form to:

To locate the nearest Beech Street Provider, contact:

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

or

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

Beech Street. A VIANT NETWORK
800-432-1776
www.beechstreet.com

Underwriting Company: Companion Life Insurance Company, Columbia, SC

NOTIFICATION OF INJURY OR SICKNESS - STUDENT INSURANCE MEDICAL CLAIM FORM

(Please Print)

COLLEGE/UNIVERSITY: ____**VALPARAISO 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: _________________________________

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 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)