STUDENT ACCIDENT COVERAGE CLAIM FORM

PART A SCHOOL STATEMENT

NAME OF CLAIMANT FIRST MI LAST | AGE | GRADE | ☐ FEMALE ☐ MALE | DATE OF BIRTH MO DAY YR

ADDRESS OF CLAIMANT | CITY | STATE | ZIP CODE

IS THE CLAIMANT A:
☐ STUDENT ☐ STAFF ☐ VOLUNTEER ☐ OTHER ______

NAME OF SCHOOL | NAME OF DISTRICT

SCHOOL MAILING ADDRESS | CITY | STATE | ZIP CODE

DURING WHAT ACTIVITY DID THE INJURY OCCUR? ☐ INTERSCHOLASTIC PRACTICE ☐ INTERSCHOLASTIC GAME ☐ P.E. ☐ CLASSROOM ☐ PLAYGROUND ☐ TRAVEL ☐ AT HOME ☐ FIELD TRIP
OTHER ______

WAS THE CLAIMANT PARTICIPATING IN A SPORT NOT SCHOOL-SPONSORED AND SUPERVISED? ☐ YES ☐ NO
IF YES, LIST NAME OF SPORTS ORGANIZATION: | TYPE OF SPORT: | DOES THE SCHOOL HAVE ANY RECORD OF ANY HEALTH COVERAGE FOR THE CLAIMANT? ☐ YES ☐ NO
If YES, name of plan:

DATE OF INJURY/SICKNESS | TIME OF INJURY : A.M. / P.M. (Circle One) | WHAT **PART** AND/OR **AREA** OF THE BODY WAS INJURED? (Additional details may be provided below) ☐ RIGHT ______ ☐ LEFT ______ | HAS THE CLAIMANT SUFFERED FROM SAME OR SIMILAR CONDITION BEFORE? ☐ YES ☐ NO IF YES, WHEN?

PROVIDE DETAILS ON HOW AND WHERE THE INJURY OR ILLNESS OCCURRED. PLEASE BE SPECIFIC

NAME AND TITLE OF SUPERVISING OFFICIAL AT TIME OF INJURY | WAS HE/SHE A WITNESS TO THE ACCIDENT? ☐ YES ☐ NO | DATE SCHOOL WAS NOTIFIED

NAME AND TITLE OF OFFICIAL COMPLETING FORM | SIGNATURE **X** | DATE SIGNED | SCHOOL TELEPHONE NUMBER

PART B PARENT OR LEGAL GUARDIAN INFORMATION

NAME OF CLAIMANT'S PRIMARY PHYSICIAN | ADDRESS | PHONE NUMBER

IS THE CLAIMANT COVERED, DIRECTLY AND/OR AS A DEPENDENT UNDER ANY OTHER INSURANCE OR HEALTH PLAN(S)? ☐ YES ☐ NO
YES, NAME OF PLAN(S) | POLICY NUMBER(S) | **IS THE CLAIMANT A MEDICARE BENEFICIARY?** ☐ **YES** ☐ **NO**

NAME OF CLAIMANT'S EMPLOYER (if applicable) | ADDRESS | PHONE NUMBER

NAME OF FATHER OR LEGAL MALE GUARDIAN | MOBILE TELEPHONE NO. | HOME TELEPHONE NO.

ADDRESS | CITY | STATE | ZIP CODE

NAME OF EMPLOYER ☐ Self Employed ☐ Part Time ☐ Unemployed | WORK TELEPHONE

ADDRESS OF EMPLOYER | CITY | STATE | ZIP CODE

NAME OF MOTHER OR LEGAL FEMALE GUARDIAN | MOBILE TELEPHONE NO. | HOME TELEPHONE NO.

ADDRESS | CITY | STATE | ZIP CODE

NAME OF EMPLOYER ☐ Self Employed ☐ Part Time ☐ Unemployed | WORK TELEPHONE

ADDRESS OF EMPLOYER | CITY | STATE | ZIP CODE

AUTHORIZATION: I hereby authorize any School, Participating Organization, Policyholder, trust, employer, insurance company, health plan, medical/dental provider or other person or entity to release any information/documentation needed to process this claim to Myers-Stevens & Toohey Co., Inc. (MST) or the AML/JIA when requested by them to do so. This may include but is not limited to: details of the reported loss; identification of witnesses and supervisors; verification of other insurance or health coverage; coverage terms; explanations of benefits; complete health records including those involving mental/emotional disorders and substance abuse; prescription drug history and fully itemized bills in the form of CMS/HCFA 1500s and UB04s. If the claim is reportedly the result of participating in a School activity, I authorize MST to share information concerning this claim as necessary with representatives of the School/School District. I understand that the authorization to release claim-related information/documentation to MST will terminate two years from the date of signature unless terminated in writing on an earlier date by me. A photo static/digital copy of this authorization shall be considered as valid and effective as the original.

NAME ______ RELATIONSHIP TO CLAIMANT ______ SIGNATURE **X** ______ DATE ______

ASSIGNMENT OF BENEFITS: I authorize the payment of benefits directly to the provider(s) of services and/or supplies associated with this claim.

NAME ______ RELATIONSHIP TO CLAIMANT ______ SIGNATURE **X** ______ DATE ______

FRAUD WARNING: Any person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete or misleading information may be prosecuted under state law.
I have read and acknowledge the General Fraud Warning above.

NAME ______ RELATIONSHIP TO CLAIMANT ______ SIGNATURE **X** ______ DATE ______