STUDENT ASSURANCE SERVICES, INC. CLAIM FORM

To submit this claim form you may either: 1. Print a copy and mail *the completed claim form with any supporting information to Student Assurance Services, Inc. P.O. Box 196, Stillwater, MN 55082;* ***2. Click on "Submit Form"*** *in the upper right hand corner of the claim form to electronically send the claim form to SAS. If you have any supporting information, send it to SAS by fax 1-651-439-0200 or mail it to SAS at the address noted above.*

Proof of Claim*: This form should be completed by the insured and submitted to SAS within 90 days from the date of treatment.*

TO PREVENT CLAIM PROCESSING DELAYS, COMPLETE ALL AREAS OF THE CLAIM FORM AND SIGN IT.

For additional questions for claim filing, refer to our website at www.sas-mn.com.

FOR OFFICE USE ONLY

Date Stamp

Name of School _____ City _____ State _____

Name of Student _____ Date of Birth _____ Soc. Sec. # _____
(Last, First, M.I.) (Month / Day / Year)

Present Address _____
(Street, City, State, Zip)

Home Address _____
(Street, City, State, Zip)

Check Student Type: ☐ Undergraduate ☐ Graduate ☐ International Email Address _____

If claim is for dependent, give name, relationship and Date of Birth _____ _____
(Month / Day / Year)

YOUR CLAIM WILL BE RETURNED IF THIS SECTION IS NOT FULLY COMPLETED BY THE INSURED

1. Date of injury or beginning of sickness/symptoms: _____
(Month/Day/Year)

2. Type of injury or sickness. What prompted your need for medical treatment? _____

   Is this work related ? ☐ Yes ☐ No _____

3. If injury, describe how and where accident occurred. Was the Injury on the left or right side of the body? ☐ Right ☐ Left (Side of Body) _____

   _____

   _____

4. If injured during practice or play of sports, what sport was involved? ☐ Intramural ☐ Intercollegiate ☐ Other

   If Other, please explain: _____

   _____

5. Were you seen or referred by the Student Health Service? ☐ No ☐ Yes If Yes, When? Date _____
(Month/Day/Year)

6. Name, address and phone number of attending physician and medical facility (Health Care Provider): _____

   _____

7. If confined to hospital, list hospital, address and phone number of hospital: Admitted _____ Discharged _____
(Month/Day/Year) (Month/Day/Year)

   _____

8. Has treatment been completed? ☐ No ☐ Yes If no, give details: _____

   _____

9. What treatment was given? _____

   _____

10. Have you had the same or similar condition before? ☐ No ☐ Yes If yes, when: _____

    If previously treated for it, give name and address of physician and hospital: _____

    _____

11. Are you covered under any other insurance, either group, individual, automobile, medical or liability? ☐ No ☐ Yes If yes, give name of company:

    _____

AUTHORIZATION: I hereby authorize any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance company, or other organization, institution, or person that has any records including all student school records or knowledge of the claimant's physical and mental health, to give the information to STUDENT ASSURANCE SERVICES, INC.. To facilitate rapid submission of such information, I authorize all said sources, to give such records or knowledge to any agency employed by the insurance company to collect and transmit such information. I understand that I have the right to withdraw in writing or refuse to sign this authorization at any time. A photocopy of this authorization shall be as valid as the original. This authorization expires one year from the date signed.

NOTICE: *Anyone who knowingly misrepresents or falsifies essential information requested by this form may upon conviction be subject to fine or imprisonment.* **For electronic filing** - By entering my name below I am indicating my intent to electronically sign this claim form and warrant that all of the information provided is true, complete, and accurate.

_____ _____
(Month / Day / Year) Signature of Claimant