

PROOF OF CLAIM

This form should be completed by the Insured and submitted to the Company within 90 days from date of treatment.

Mail Completed Form To:
STUDENT ASSURANCE SERVICES, INC.
 P.O. Box 196
 STILLWATER, MN 55082-0196

NOTICE: Anyone who knowingly misrepresents or falsifies essential information requested by this form may upon conviction be subject to fine or imprisonment.

Name of School _____ City _____ State _____

Name of Student _____ (Last) _____ (First) _____ (M.I.) Date of Birth ____/____/____ Soc. Sec. # _____ - _____ - _____

Present Address _____ (Street) _____ (City) _____ (State) _____ (Zip) Check Undergraduate
 Student Graduate
 Type: International

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

Email Address _____

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

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

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?) Please Explain Is this work related? <input type="checkbox"/> Yes <input type="checkbox"/> No	→ _____									
3. If injury, describe how and where accident occurred. Give complete details, including left or right side of the body.	<input type="checkbox"/> Right <input type="checkbox"/> Left (Side of Body)									
4. If injured during practice or play of sports, what sport was involved?	<table style="width: 100%; border: none;"> <tr> <td style="border: none;">Check</td> <td style="border: none;">Intramural</td> <td style="border: none;"><input type="checkbox"/></td> </tr> <tr> <td style="border: none;">One:</td> <td style="border: none;">Intercollegiate</td> <td style="border: none;"><input type="checkbox"/></td> </tr> <tr> <td style="border: none;"></td> <td style="border: none;">Other</td> <td style="border: none;"><input type="checkbox"/></td> </tr> </table>	Check	Intramural	<input type="checkbox"/>	One:	Intercollegiate	<input type="checkbox"/>		Other	<input type="checkbox"/>
Check	Intramural	<input type="checkbox"/>								
One:	Intercollegiate	<input type="checkbox"/>								
	Other	<input type="checkbox"/>								
5. Were you seen or referred by the Student Health Service?	<input type="checkbox"/> No <input type="checkbox"/> 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. Dates confined:	Hospital _____ Admitted _____ Discharged _____									
8. Has treatment been completed? What treatment was given?	<input type="checkbox"/> No <input type="checkbox"/> Yes If no, give details _____									
9. Have you had the same or similar condition before? (If previously treated for it, give name and address of physician and name of hospital.)	<input type="checkbox"/> No <input type="checkbox"/> Yes If yes, when _____									
10. Are you covered under any other insurance, either group, individual, automobile, medical or liability?	<input type="checkbox"/> No <input type="checkbox"/> Yes If yes, give name of company _____									

ASSIGNMENT OF BENEFITS: I hereby authorize the Insurance Company to pay directly to _____

Hospital, all hospital expense benefits and directly to Dr. _____ all doctor expense benefits due me under my Student Insurance for expenses described in the statements rendered. I will pay all expenses in excess of the benefits provided by my Student Insurance. If you have already paid the medical expenses, we will reimburse you if you can provide a paid receipt with this form.

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 or knowledge of the claimant's physical 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. A photocopy of this authorization shall be as valid as the original. This authorization expires one year from the date signed.

_____ Date _____ Signature of Claimant

FOR OFFICE USE ONLY

Date Stamp