

NAME OF SCHOOL: Dominican University of California HEALTH CENTER REFERRAL: No Yes IF YES, REFERRAL MUST BE ATTACHED

POLICY NUMBER: DSP00017-07 REFERRAL GIVEN BY: _____ DATE: _____

MAIL TO: Delos Insurance Company, Personal Insurance Administrators, Inc., P.O. Box 6040, Agoura Hills, CA 91376-6040, 1-800-468-4343

Name of Student _____ Student ID Number _____ S.S. Number _____ Date of Birth _____

Current Home Address _____
Number and Street _____ City _____ State _____ Zip Code _____ Phone Number _____

Name of Insured Dependent _____ Date of Birth _____
if applicable

Current Home Address _____
Number and Street _____ City _____ State _____ Zip Code _____

- CLAIM WILL BE RETURNED IF THIS SECTION IS NOT FULLY COMPLETED
1. Date of injury or beginning of sickness _____ When was physician first consulted? _____
 2. Nature of injury or sickness _____
 3. If injury, describe how and where accident occurred _____
 4. Did injury occur during practice or play of sports? No Yes
If yes, please check one of the following: Intramural/Club Name of Sport _____
 Intercollegiate Signature of Athletic Trainer _____
 Other _____
 5. Have you suffered same or similar condition before? No Yes
If yes, and you were previously treated for it, dates treated: _____
Name and address of physician who treated you: _____
 6. If hospitalized at that time, date confined to hospital: _____
Name and address of hospital: _____
 7. Was the injury the result of a motor vehicle accident? No Yes

Do you have other insurance which covers your condition (group, individual, automobile, medical or liability)? No Yes
If yes, who is the Holder of Policy: Self Parent Spouse Give name of company _____
If covered under Parent's/Spouse's Insurance or if privately insured, please include the following information:
Policy No. _____ Group No. _____ Phone No. of Insurance Co. _____
Parent's/Spouse's Name (Holder of Policy) _____ S.S. No. _____
Employer's Name and Address _____

Have you been insured under another health insurance plan any time during the past 12-month period? No Yes
If yes, give name of company and attach a copy of your Certificate of Prior Coverage _____
Address: _____ Phone Number: _____
Policy Number: _____ Effective Date of Coverage: _____ Date Coverage Terminated: _____

ASSIGNMENT OF BENEFITS
CLAIMANT (OR PARENT, IF MINOR) MUST COMPLETE IN FULL INDICATING TO WHOM PAYMENT IS TO BE MADE. (PLEASE PRINT.)
Dr.: _____ Hosp: _____ Other: _____

Address Address Address

City State City State City State

IMPORTANT: THIS FORM MUST BE COMPLETED AND RETURNED TO THE COMPANY WITHIN 90 DAYS FROM THE DATE OF TREATMENT ACCOMPANIED BY ALL BILLS INCURRED TO THAT DATE. PLEASE ATTACH ITEMIZED BILLS.

For your protection, State Law requires that the following appear on this form: "Any Person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison."

AUTHORIZATION: I hereby authorize Delos Insurance Company, or its representative, to inspect or secure copies of case history records, laboratory reports, diagnosis, prognosis, x-rays, and any other data covering this and/or previous confinements and/or disabilities. A photostatic copy of this authorization shall be deemed as effective and valid as the original.

I hereby authorize Delos Insurance Company to pay bills in connection with this claim directly to the Doctor, Hospital or Other Payee indicated above. I understand that I or my authorized representative is entitled to receive a copy of this authorization upon request.

SIGNATURE OF STUDENT _____ DATE _____