

NAME OF SCHOOL: \_\_\_\_\_ HEALTH CENTER REFERRAL: No  Yes  IF YES, REFERRAL MUST BE ATTACHED

POLICY NUMBER: 302-093-0208 REFERRAL GIVEN BY: \_\_\_\_\_ DATE: \_\_\_\_\_

MAIL TO: Nationwide Life Insurance Company, Personal Insurance Administrators, Inc., P.O. Box 6040, Agoura Hills, CA 91376-6040, 1-800-314-3938

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

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 (unless previously submitted) \_\_\_\_\_

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 Nationwide Life 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 Nationwide Life 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 \_\_\_\_\_