

SNOW COLLEGE
Student Accident Insurance Plan
Claim Form

Please mail claim form and direct all claim inquiries to:
Personal Insurance Administrators, Inc.
P.O. Box 6040
Agoura Hills, CA 91376-6040
(800) 468-4343

Claim Filing Instructions:

1. Claim form must be fully completed and signed by claimant and appropriate college official.
2. Submit itemized bills—balance due bills are not acceptable for payment.
3. Section 3 must be answered in full. If you do have other coverage make sure explanation of benefits or denial letters are attached.

TO BE COMPLETED BY STUDENT

Student's Full Name _____

Street Address _____

City _____

Zip _____

Date of Birth _____

Social Security # _____

Telephone # _____

1. Give a full description of the injury from which you are now suffering: _____
 When did it happen? _____ Where did it happen? _____
 How did it happen? _____

2. Give exact date & time when injury occurred: Date _____ Time _____ AM / PM

3. I have other Insurance coverage through:

(A) Parent Self Spouse Employer
 Type of coverage: Individual Group

(B) Parent Self Spouse Employer
 Type of coverage: Individual Group

Name of policyholder: _____
(parent/self/spouse/employer, if applicable)

Name of policyholder: _____
(parent/self/spouse/employer, if applicable)

Social Security # of policyholder: _____
(parent/self/spouse)

Social Security # of policyholder: _____
(parent/self/spouse)

Employer's Phone No. and Address (if applicable): _____

Employer's Phone No. and Address (if applicable): _____

Type of Plan: HMO Other

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Insurance Company Name & Policy No. _____

Insurance Company Name & Policy No. _____

TO BE COMPLETED BY COLLEGE OFFICIAL

Did accident occur (check yes or no):

Yes No

Yes No

(a) While claimant was supervised?

(d) On school premises?

(b) During sponsored activity?

(e) While traveling to or from a regularly
scheduled activity in a supervised group?

(c) During programmed hours?

I hereby certify that the statements made above are correct to the best of my knowledge and belief and that the above named claimant was enrolled and registered at the college at the time of the accident.

Signature of College Official: _____ Title: _____ Date: _____

INTERCOLLEGIATE ATHLETIC ACCIDENTS—TO BE COMPLETED BY ATHLETIC OFFICIAL

I hereby certify that the above injury was sustained while participating in official activities under adequate organizational supervision on :

Name of Intercollegiate Sport: _____ Position Played: _____ Practice Competition

Signature of Athletic Official: _____ Title: _____ Date: _____

AUTHORIZATION TO PAY BENEFITS TO PROVIDER

I authorize payment of medical payments to physician or supplier for services described for the attached statements.

Student Signature: _____ Date: _____

I hereby authorize any insurance company, hospital, physician or other person who has attended or examined me to disclose when requested to do so, all information with respect to any injury, policy coverage, medical history, consultation, prescription or treatment, and copies of all hospital or medical records. A photocopy of the authorization shall be considered as effective and valid as the original. I understand that I or my authorized representative is entitled to receive a copy of this authorization upon request.

For your protection State law requires the following statement to appear on this form: any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Student Signature: _____ Date: _____