

**NAME OF SCHOOL:** UC Santa Barbara—USHIP **HEALTH CENTER REFERRAL:** No  Yes  **IF YES, REFERRAL MUST BE ATTACHED**

**POLICY NUMBER:** 302-079-0408 **REFERRAL GIVEN BY:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

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

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 \_\_\_\_\_ S.S. No. \_\_\_\_\_ 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**
- Date of injury or beginning of sickness \_\_\_\_\_ When was physician first consulted? \_\_\_\_\_
  - Nature of injury or sickness \_\_\_\_\_
  - If injury, describe how and where accident occurred \_\_\_\_\_
  - 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 \_\_\_\_\_
  - 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: \_\_\_\_\_
  - If hospitalized at that time, date confined to hospital: \_\_\_\_\_  
 Name and address of hospital: \_\_\_\_\_
  - 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, USHIP is secondary.**  
 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**

PARENT (OR CLAIMANT, IF ADULT) 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** \_\_\_\_\_