

**National Union Fire Insurance
Company of Pittsburgh, Pa.**

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

CLAIM FORM

**COMPLETE IN DETAIL
TO ENSURE
PROMPT HANDLING**

COVERAGE VERIFIED

**PLEASE PRINT ALL
INFORMATION**

SPECIAL NOTICE: 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."

FORM MUST BE COMPLETED AND SIGNED

Name of School Woodbury University		Policy Number CHH0058781	Birth Date	
Insured's Name				
LAST NAME		FIRST NAME	MI	INSURED'S SOCIAL SECURITY #
Present Address				PHONE
NO. AND STREET		CITY OR TOWN	STATE	ZIP+4
Home Address				
NO. AND STREET		CITY OR TOWN	STATE	ZIP+4
If claim for dependents, give dependent's name:		Relationship to Insured	Birth Date	

MUST BE COMPLETED	Are you covered (as an insured or dependent) by any other hospital and/or medical plan? <input type="checkbox"/> Yes, Insured <input type="checkbox"/> Yes, Dependent <input type="checkbox"/> No			
	If yes, please check one: <input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Automobile/ Medical			
	If yes, also indicate name and policy number of insurance company.			
	Name of Insured	Policy #/ Group #	I.D. #	Company
	Have you filed a claim with the above company? <input type="checkbox"/> Yes <input type="checkbox"/> No			
	Send copies of all Explanation of Benefits showing benefits paid and/or benefits denied to the Company at the address above.			
Name and Address of Employer of:				
<input type="checkbox"/> Insured, if employed				
<input type="checkbox"/> Spouse, in insured is married				

1. Date of accident or sickness:	Date of first treatment:		
2. Nature of sickness or injury:			
3. If injury, describe how and when accident occurred and indicate if work-related:			Work-related? <input type="checkbox"/> Yes <input type="checkbox"/> No
4. If injured in practice or play of a sport, indicate which sport:	Check One:	<input type="checkbox"/> Club <input type="checkbox"/> Intercollegiate <input type="checkbox"/> Other	COMPLETE SPORTS INJURY SECTION BELOW.
5. Have you previously been troubled with this condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date:	
6. Give names of all other physicians consulted			
7. Were you hospitalized for this condition? If so, where and what dates?	Where?	From:	To:
8. Were you referred by a student health center?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, attach referral to claim form.	

PAYMENT WILL BE MADE TO THE PROVIDERS OF SERVICE (Hospital, Doctor, and others), UNLESS A PAID RECEIPT OR STATEMENT ACCOMPANIES THE BILL AT THE TIME THE CLAIM IS SUBMITTED.

SPORTS INJURIES - IMPORTANT: ALL INTERCOLLEGIATE SPORTS CLAIMS MUST BE SIGNED BY AN AUTHORIZED ATHLETIC OR SCHOOL OFFICIAL.

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

Signature of School Official _____ **Title** _____ **Date** _____

To any medical care provider, medical care facility, insurer, government-sponsored health plan, or employer: I permit (while my claim is pending) the release of any medical information about me to the Company and its representatives. The Company's representatives include re-insuring companies and other persons or groups performing business of legal services relating to my claim. This applies to all information about the diagnosis, treatment, or prognosis or any illness or injury I now have or have had in the past. The Company will use this information to find out if my claim is eligible. A copy of this authorization (one of which will be given to me by the Company upon my request) will be as valid as this one.

I certify that the above information given by me in support of this claim is true and correct.

Patient's or Authorized Representative's Signature _____ **Date** _____

If Authorized Representative, Relationship to Patient _____

Address _____

STREET CITY STATE ZIP+4