

When completed, return this form to the Plan Administrator:



COMMERCIAL TRAVELERS
70 GENESEE STREET
COMMERCIAL TRAVELERS BUILDING
UTICA, NEW YORK 13502
1-800-756-3702

Please check the correct Underwriting Company:

- Commercial Travelers Mutual Insurance Company
Security Mutual Life Insurance Company

IMPORTANT: Please attach itemized bills. This form MUST be completed in full and returned to the company WITHIN 90 DAYS from the date of treatment accompanied by all itemized bills received to date. Mail to the address shown on this form. Payments will be made to the service provider unless otherwise advised.

CLAIM CANNOT BE PROCESSED WITHOUT THIS INFORMATION

Form with fields for College (or) University, Student's Name, Policy #, Date of Birth, and Mailing Address.

1. Date of injury (or) onset of sickness... When was physician first consulted?
Nature of illness (or) injury
If injury, (a) How and where did accident occur?
(b) Were you practicing or playing any intercollegiate... sport at the time of the accident?
(c) IF AN INTERCOLLEGIATE ACCIDENT, THIS FORM MUST BE SIGNED BY THE ATHLETIC DEPARTMENT

Signature of Athletic Department Official Title Date

2. Were you treated and/or referred by the Student Health Service?
3. Hospital (Give name, address and date of confinement)
4. Give names, addresses and telephone numbers of all attending physicians
5. Give name, address and telephone number of usual family physician
6. Have you suffered same or similar condition in the past?
7. Was injury the result of a motor vehicle accident?
8. Are you employed full-time?
9. Father's Name SS# Father's Employer-Name Address Employer's Phone #
10. Mother's Name SS# Mother's Employer-Name Address Employer's Phone #
11. Spouse's Name SS# Spouse's Employer-Name Address Employer's Phone #
12. Do you, your spouse or your parents have other insurance or medical plan which covers this condition...

I hereby authorize any physician, hospital, company, employer, or organization to release any information regarding the medical history, treatment, or benefits payable for this claim...

Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information...

I hereby CERTIFY that I have read the answers to all parts of this form and to the best of my knowledge and belief the information is complete and correct as given herein.

Name of student Date

Signature of claimant (parent or guardian if not adult)

Student's Address While at School Street City State Zip