

NOTIFICATION OF INJURY OR SICKNESS - STUDENT INSURANCE MEDICAL CLAIM FORM

When completed, return this form to the Plan Administrator:

Special Risk Claims

**Commercial Travelers Mutual Insurance Co,
70 Genesee Street, Utica NY 13502, Toll Free: 800-756-3702**

(Please Print)

College/University: Denison University Policy No: 2006M3A97

Student Name: _____ Male Female

Social Security No.: _____ or Student ID No.: _____ Date of Birth: _____

Current Address: _____
(Street) (City) (State) (Zip Code)

1. Date of Injury (or) onset of Sickness: _____ When was physician First Consulted? _____

2. Nature of Injury (or) Illness: _____

3. If Injury, (a) how and where did accident occur? _____

(b) Were you practicing or playing any intercollegiate (between rival colleges) sport at the time of the Accident? Yes No

If "yes", name the Sport: _____ Approved by: _____
(Athletic Trainer or Director)

4. Were you treated and/or referred by the Student Health Center? Yes No If "Yes", date: _____

5. Have you suffered same or similar condition in the past? Yes No If "Yes", and you were treated for it, please give name and address of the physician who treated you.

Name: _____ Date Treated: _____

Address: _____

6. Was injury the result of a motor vehicle accident? Yes No

7. Was the injury or sickness a result of your employment? Yes No

8. Do you, your spouse, or your parents have any other insurance or medical plan that covers this condition, either Group, Individual, Automobile, or Liability? Yes No If "Yes", Please complete the reverse side of this form.

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 to the Insurance Company checked above. A photocopy of this authorization shall be as valid as the original. I agree that all information provided in this document is accurate and complete to the best of my knowledge. I understand that any incorrect or undisclosed information can result in duplicate payments creating a substantial overpayment. Such overpayment will be the obligation of the undersigned, with responsibility to reimburse in full, upon request, all amounts deemed refundable. **Any Person who intentionally includes false or misleading information in an attempt to defraud or deceive is guilty of a crime. 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.**

Signature: _____ Date: _____
(Insured Student)

OTHER INSURANCE INFORMATION:

FATHER'S NAME: _____.

Social Security Number: _____ Employed? Yes No

Employer: _____.

Employer's Address: _____.

Phone Number: _____ Contact Person: _____.

Does your father have group Medical Insurance coverage through his employment? Yes No

Insurance Company: _____.

Address: _____.

Policy No.: _____.

MOTHER'S NAME: _____.

Social Security Number: _____ Employed? Yes No

Employer: _____.

Employer's Address: _____.

Phone Number: _____ Contact Person: _____.

Does your mother have group Medical Insurance coverage through his employment? Yes No

Insurance Company: _____.

Address: _____.

Policy No.: _____.

Type of PLAN:

Health Maintenance Organization (HMO) Preferred Provider Organization (PPO) Standard Medical &

Hospitalization Coverage Other (Describe): _____.

If you mother or father have medical insurance coverage and are not covered, or are partially covered, due to policy limitations, please explain:

_____.

If you have medical insurance coverage as an eligible dependent from a parent's previous marriage, as mandated in a divorce decree, please give details for filing a claim:

_____.