

To locate the nearest Beech Street Provider, contact:

When Completed, return this form to the Plan Administrator:



Special Risk Claims
Commercial Travelers Mutual Ins. Co.
70 Genesee St., Utica NY 13502, Toll Free: 800-756-3702
Please check the correct Underwriting Company:

Commercial Travelers Mutual Insurance Company Security Mutual Life Insurance Company

NOTIFICATION OF INJURY OR SICKNESS - STUDENT INSURANCE MEDICAL CLAIM FORM

(Please Print) COLLEGE/UNIVERSITY: POLICY NO:

Student Name: Male Female

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

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

If Claim is for Dependent:
Name of Dependent:
Male Female Date of Birth: Relationship:

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?

(Please use back of Claim Form if Needed)

(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:

Referred by: (College Physician or College Nurse)

5. Have you suffered same or similar condition in the past? Yes No If "Yes", and if 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. a) Do you, your spouse or your parents have any other insurance or medical plan that covers this condition, either Group, Individual, Automobile, Medical or Liability? Yes No

b) Please complete Page 2 of this form.

**OTHER INSURANCE INFORMATION:**

**FATHER'S  
NAME:** \_\_\_\_\_

**Social Security Number:** \_\_\_\_\_ **Employed** Yes \_\_\_\_ No \_\_\_\_

**Employer:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_ **Contact Person:** \_\_\_\_\_

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

**Insurance Company:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Policy No.:** \_\_\_\_\_

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**MOTHER'S NAME:** \_\_\_\_\_

**Social Security Number:** \_\_\_\_\_ **Employed** Yes \_\_\_\_ No \_\_\_\_

**Employer:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_ **Contact Person:** \_\_\_\_\_

**Does your mother have group Medical Insurance coverage through her employment?** Yes \_\_\_\_ No \_\_\_\_

**Insurance Company:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Policy No.:** \_\_\_\_\_

**TYPE OF PLAN:**

\_\_\_ Health Maintenance Organization (HMO) \_\_\_ Preferred Provider Organization (PPO) \_\_\_ Standard Med. & Hospitalization Cov.

\_\_\_ Other (Describe): \_\_\_\_\_

If your mother or father have medical insurance coverage and your 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 parents' previous marriage, as mandated in a divorce decree, please give details for filing a claim: \_\_\_\_\_

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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. I also authorize the Insurance Company checked above or their representatives to pay all bills in connection with this claim directly to the doctor, hospital or any other persons rendering service, and such payment shall release the Insurance Company from liability as to amounts so paid. **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: \_\_\_\_\_  
(Please Print, Sign and Date Completed Claim Form)

Date: \_\_\_\_\_