PROOF OF CLAIM

This form should be completed by the Insured and submitted to the Company within 90 days from date of treatment.

Mail Completed Form To:
STUDENT ASSURANCE SERVICES, INC.
P.O. Box 196
STILLWATER, MN 55082-0196

NOTICE: *Anyone who knowingly misrepresents or falsifies essential information requested by this form may upon conviction be subject to fine or imprisonment.*

Name of School _____ City _____ State _____

Name of Student _____ Date of Birth ___/___/___ Soc. Sec. # ☐☐☐-☐☐-☐☐☐☐
(Last) (First) (M.I) (Month / Day / Year)

Present Address _____
(Street) (City) (State) (Zip)

Home Address _____
(Street) (City) (State) (Zip)

Check Student Type: Undergraduate ☐ Graduate ☐ International ☐

Email Address _____

If claim is for dependent, give name, relationship and Soc. Sec. Number _____ ☐☐☐-☐☐-☐☐☐☐

YOUR CLAIM WILL BE RETURNED IF THIS SECTION IS NOT FULLY COMPLETED BY THE INSURED

1. Date of injury or beginning of sickness/symptoms.	_____, 20 _____ Time _____ M
2. Type of injury or sickness. (What prompted your need for medical treatment?) Please Explain → Is this work related? ☐ Yes ☐ No	
3. If injury, describe how and where accident occurred. Give complete details, including left or right side of the body.	☐ Right ☐ Left (Side of Body)
4. If injured during practice or play of sports, what sport was involved?	*Check One:* Intramural ☐ Intercollegiate ☐ Other ☐
5. Were you seen or referred by the Student Health Service?	☐ No ☐ Yes When? Date _____
6. Dates confined to hospital.	From _____ To _____
Name and address of hospital.	Hospital _____
7. Name and address of primary/family physician.	
8. Has treatment been completed? What treatment was given? What is the final diagnosis?	☐ No ☐ Yes If no, give details _____
9. Have you suffered same or similar conditions before? (If previously treated for it, give name and address of physician and name of hospital.)	☐ No ☐ Yes If yes, when _____
10. Do you have other insurance, either group, individual, automobile medical or liability?	☐ No ☐ Yes If yes, give name of company _____

ASSIGNMENT OF BENEFITS: I hereby authorize the Insurance Company to pay directly to _____

Hospital, all hospital expense benefits and directly to Dr. _____ all doctor expense benefits due me under my Student Insurance for expenses described in the statements rendered. I will pay all expenses in excess of the benefits provided by my Student Insurance. If you have already paid the medical expenses, we will reimburse you if you can provide a paid receipt with this form.

AUTHORIZATION: I hereby authorize any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance company, or other organization, institution, or person that has any records or knowledge of the claimant's physical health, to give the information to STUDENT ASSURANCE SERVICES, INC.. To facilitate rapid submission of such information, I authorize all said sources, to give such records or knowledge to any agency employed by the insurance company to collect and transmit such information. A photocopy of this authorization shall be as valid as the original. This authorization expires one year from the date signed.

_____ _____
Date Signature of Claimant

FOR OFFICE USE ONLY

Date Stamp

Form CLM-8(09)