PROOF OF CLAIM

This form must be completed and submitted to the Company within 90 days from date of injury.

Mail completed form to:
STUDENT ASSURANCE SERVICES, INC.
P.O. BOX 196
STILLWATER, MINNESOTA 55082-0196

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

CLAIM PROCEDURE:

1. A college official must complete PART A.
2. The Insured Student should complete PART B. The Insured Student's parents or guardian should complete PART C.
3. If dental injury, please also complete back of this form.
4. See reverse side for important claim procedures.

PART A - (To be completed by a college official)

1. Name of College _____

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

2. Name of Insured _____

3. Date of injury _____ ❒ AM ❒ PM

4. Under whose supervision? _____ Was He/She a witness? _____

5. Where did the accident happen? _____

6. During what activity/sport did the accident happen? _____

7. How did the accident happen? Give complete details _____

   _____

8. Part of body injured _____ ❒ R ❒ L

   Reported By: _____
   (Signature of College Official) (Title) (Date)

PART B - (To be completed by the Insured Student)

1. Student's Name _____ Phone _____

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

   Email Address _____

   Soc. Sec. # of Insured ☐☐☐-☐☐-☐☐☐☐ Date of Birth ____/____/____
   (Month / Day / Year)

2. Are you employed? If so, name of employer _____

3. List your family or group insurance policies:

   Name of Insurance Company _____ Policy No. _____

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

PART C - (To be completed by the Insured Student's Parents or Guardian)

1. Parent's/Guardian's Name _____ Home Phone _____

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

2. Father's Occupation _____ Employer _____

   Mother's Occupation _____ Employer _____

3. List your family or group insurance policies:

   Name of Insurance Company _____ Policy No. _____

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

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 or mental 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) (Print Name of Student/Patient) (Student Signature or Parent/Guardian Signature, if Student is under 18 years)

STEPS TO FOLLOW WHEN FILING A CLAIM:

1. A college official **must** complete Part A for all college related accidents. The Insured student should complete PART B. The Insured student's parents or guardian should complete PART C. **Do NOT leave this Claim Form with the physician or hospital. Complete and submit directly to the Claims Office at the address indicated below.**

2. Send copies of **itemized bills**. These are the original billings you receive, not monthly statements. **All bills must include the provider's Tax ID Number.**

3. Submit copies of all bills to your family and/or group insurance, even if you have a large deductible. This plan is supplemental to all other valid coverage. You must file a claim with your other insurance first. This plan does not cover penalties imposed for failure to use providers preferred or designated by your primary coverage. After you have received payment or copies of "Explanation of Benefits" (EOB) from your family insurance company or insurance administrator (Blue Cross, Group Health, Prudential Insurance, etc.), **send our claim form, copies of itemized bills and your other insurance E.O.B.'s to:**

STUDENT ASSURANCE SERVICES, INC.
P.O. BOX 196
STILLWATER, MN 55082-0196

NO CLAIM CAN BE PROCESSED UNTIL ALL OF THE ABOVE DOCUMENTS ARE PROVIDED.

4. Students must be treated by a licensed medical physician within the required time as stated in the policy.

5. Proof of claim should be submitted within 90 days from the date of injury, or a reasonable time thereafter not to exceed one year.

6. The policy allows benefits for expenses actually incurred within the required time as stated in the policy.

THE MASTER POLICY IS ISSUED TO THE COLLEGE . THE POLICY CAN BE VIEWED AT THE COLLEGE OFFICE.

ATTENDING DENTIST'S STATEMENT

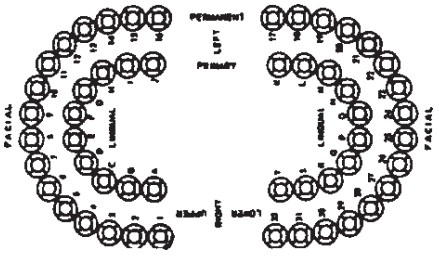
(1) DATE OF ACCIDENT

(2) IF PROTHESIS, IS THIS INITIAL PLACEMENT? ☐ YES ☐ NO

(3) WERE THE TEETH SOUND OR NATURAL PRIOR TO THE CURRENT TREATMENT? ☐ YES ☐ NO

(4) ARE ANY SERVICES COVERED BY ANOTHER PLAN? IF SO, NAME PLAN ☐ YES ☐ NO

IDENTIFY ALL TEETH WITH AN "X" THAT WERE INVOLVED IN THIS ACCIDENT



TOOTH NO.	DESCRIPTION OF SERVICE	DATE OF SERVICE	FEE
		TOTAL FEE	

X

DENTIST'S NAME | SIGNATURE | DEGREE

STREET ADDRESS | DATE

CITY | STATE | ZIP | TELEPHONE ( )

Federal ID Number — No benefits can be paid until we have your ID number.