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 Date of Birth _____ ____/____/____
(Month / Day / Year)

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

1. Date of injury or beginning of sickness/symptoms	_____ (Month/Day/Year)
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 _____ (Month/Day/Year)
6. Name, address and phone number of attending physician and medical facility (Health Care Provider).	Michigan Avenue Immediate Care 312 201 1234 104 S. Michigan Ave. Chicago, IL 60603
7 If confined to hospital, list hospital, address and phone number of hospital. Dates confined:	Hospital _____ Admitted _____ Discharged _____
8. Has treatment been completed? What treatment was given?	☐ No ☐ Yes If no, give details _____
9. Have you had the same or similar condition before? (If previously treated for it, give name and address of physician and name of hospital.)	☐ No ☐ Yes If yes, when _____
10 Are you covered under any 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 Michigan Avenue Immediate Care Hospital, all hospital expense benefits and directly to Dr. Michigan Avenue Immediate Care. 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(7-09)