myers | stevens | toohey

STUDENT ACCIDENT & SICKNESS INSURANCE CLAIM FORM

SUBMIT

PART A SCHOOL STATEMENT (Parent or legal guardian may complete Part A if injury is not school related)

NAME OF CLAIMANT FIRST MI LAST | AGE | GRADE | ☐ FEMALE ☐ MALE | DATE OF BIRTH MO / DAY / YR

ADDRESS OF CLAIMANT CITY STATE ZIP CODE

IS THE CLAIMANT A: ☐ STUDENT ☐ STAFF ☐ VOLUNTEER ☐ OTHER _____

ID # FROM ID CARD (If applicable)

NAME OF SCHOOL

NAME OF DISTRICT (if applicable)

SCHOOL MAILING ADDRESS CITY STATE ZIP CODE

INJURY OCCURED: ☐ Interscholastic Practice ☐ Interscholastic Game ☐ P.E. ☐ Classroom ☐ Travel ☐ At Home ☐ Field Trip ☐ Other _____

WAS THE CLAIMANT PARTICIPATING IN A SPORT NOT SCHOOL SPONSORED AND SUPERVISED? ☐ YES ☐ NO
IF YES, LIST NAME OF SPORTS ORGANIZATION:

DOES THE SCHOOL HAVE ANY RECORD OF ANY HEALTH COVERAGE FOR THE CLAIMANT? YES ☐ NO ☐
If YES, name of plan:

DATE OF INJURY/ONSET OF SICKNESS MO / DAY / YR

TIME OF INJURY : A.M. / P.M. (CIRCLE ONE)

WHAT **PART** OF THE BODY WAS INJURED? ☐ LEFT ☐ RIGHT

HAS THE CLAIMANT SUFFERED FROM SAME OR SIMILAR CONDITION BEFORE? ☐ YES ☐ NO IF YES, WHEN?

PROVIDE DETAILS ON HOW AND WHERE THE INJURY OCCURRED. PLEASE BE SPECIFIC

NAME AND TITLE OF SUPERVISING OFFICIAL AT TIME OF INJURY

WAS HE/SHE A WITNESS TO THE ACCIDENT? ☐ YES ☐ NO

DATE SCHOOL WAS NOTIFIED / /

NAME AND TITLE OF OFFICIAL COMPLETING FORM

SIGNATURE X

DATE SIGNED

SCHOOL TELEPHONE NUMBER ( )

PART B PARENT OR LEGAL GUARDIAN INFORMATION

NAME OF CLAIMANT'S PRIMARY PHYSICIAN | ADDRESS | PHONE NUMBER ( )

IS THE CLAIMANT COVERED, DIRECTLY AND/OR AS A DEPENDENT UNDER ANY OTHER INSURANCE OR HEALTH PLAN(S)? ☐ YES ☐ NO
IF YES, NAME OF PLAN(S) | POLICY NUMBER(S)

NAME OF CLAIMANT'S EMPLOYER (if applicable) | ADDRESS | PHONE NUMBER ( )

NAME OF FATHER OR LEGAL MALE GUARDIAN | MOBILE TELEPHONE NO. ( ) | HOME TELEPHONE NO. ( )

ADDRESS CITY STATE ZIP CODE

NAME OF EMPLOYER ☐ Self Employed ☐ Part Time ☐ Unemployed | WORK TELEPHONE ( )

ADDRESS OF EMPLOYER CITY STATE ZIP CODE

NAME OF MOTHER OR LEGAL FEMALE GUARDIAN | MOBILE TELEPHONE NO. ( ) | HOME TELEPHONE NO. ( )

ADDRESS CITY STATE ZIP CODE

NAME OF EMPLOYER ☐ Self Employed ☐ Part Time ☐ Unemployed | WORK TELEPHONE ( )

ADDRESS OF EMPLOYER CITY STATE ZIP CODE

AUTHORIZATION: *I hereby authorize any School, Participating Organization, Policyholder, trust, employer, insurance company, health plan, medical/dental provider or other person or entity to release any information/documentation needed to process this claim to Myers-Stevens & Toohey & Co., Inc. (MST) or its insuring company when requested by them to do so. This may include but is not limited to: details of the reported loss; identification of witnesses and supervisors; verification of other insurance or health coverage; coverage terms; explanations of benefits; complete health records including those involving mental/emotional disorders and substance abuse; prescription drug history and fully itemized bills in the form of CMS/HCFA 1500s and UB04s. If the claim is reportedly the result of participating in a School, Participating Organization or Policyholder activity, I authorize MST to share information concerning this claim as necessary with representatives of the School, Participating Organization or Policyholder as applicable. I understand that the authorization to release claim-related information/documentation to MST will terminate two years from the date of signature unless terminated in writing on an earlier date by me. A photo static/digital copy of this authorization shall be considered as valid and effective as the original.*

NAME _____ RELATIONSHIP TO CLAIMANT _____ SIGNATURE **X** _____ DATE _____

ASSIGNMENT OF BENEFITS: *I authorize the payment of benefits directly to the provider(s) of services and/or supplies associated with this claim.*

NAME _____ RELATIONSHIP TO CLAIMANT _____ SIGNATURE **X** _____ DATE _____

FRAUD WARNING: *Any person who knowingly and with intent to defraud any insurance company or other persons, files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime, subject to criminal prosecution and/or civil penalties.*
I have read and acknowledge the General Fraud Warning above and the specific version for my state on the reverse side.

NAME _____ RELATIONSHIP TO CLAIMANT _____ SIGNATURE **X** _____ DATE _____