

COVERAGE VERIFIED

**PLEASE PRINT ALL
INFORMATION**

SPECIAL NOTICE: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, and any person who knowingly makes or knowingly assists, abets, solicits or conspires with another to make a false report of the theft, destruction, damage or conversion of any motor vehicle to a law enforcement agency, the department of motor vehicles or an insurance company commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the value of the subject motor vehicle or stated claim for each violation.

PART 1 – MUST BE COMPLETED AND SIGNED

| | | |
|---|--|---------------|
| Name of School <p style="text-align: center;">ADELPHI UNIVERSITY</p> | Policy Number <p style="text-align: center;">CHH0084931</p> | Birth Date |
| Insured's Name | INSURED'S STUDENT ID # | PHONE |
| Present Address | CITY OR TOWN | STATE ZIP + 4 |
| Home Address | CITY OR TOWN | STATE ZIP + 4 |

If claim for dependent, give dependent's name _____, relationship to insured _____, D.O.B. _____

| | |
|--------------------------|---|
| MUST BE COMPLETED | Are you covered (as an insured or dependent) by any other hospital and/or medical plan? <input type="checkbox"/> Yes Insured <input type="checkbox"/> Yes Dependent <input type="checkbox"/> No |
| | If yes, please check one: <input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Automobile/Medical |
| | If yes, also indicate name and policy number of insurance company. |
| | Name of Insured: _____ Policy #/Group #: _____ I.D. # _____ Company _____ |
| | Have you filed a claim with the above company? <input type="checkbox"/> Yes <input type="checkbox"/> No |

Send copies of all Explanation of Benefits showing benefits paid and/or benefits denied to the Company at the address above.

Name and Address of Employer of:
 Insured, if employed _____
 Spouse, if insured is married _____

| | | |
|--|---|---|
| 1. Date of accident or sickness | Date of first treatment. | |
| 2. Nature of sickness or injury. | | |
| 3. If injury, describe how and when accident occurred and indicate if work related | | |
| *4. If injured in practice or play or sport, indicate which sport. | Check One: | <input type="checkbox"/> Intramural <input type="checkbox"/> Intercollegiate <input type="checkbox"/> Other |
| 5. Have you previously been troubled with this condition? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Date _____ |
| 6. Give name of all other physicians consulted | | |
| 7. Hospitalized? If so, where and what dates | Where? _____ | From: _____ To: _____ |
| 8. Health Center referral? | <input type="checkbox"/> Yes <input type="checkbox"/> No | If yes, attach referral to claims form. If no, please explain _____ |

PAYMENT WILL BE PAID TO THE PROVIDERS OF SERVICE (Hospital, Physician and others), UNLESS A PAID RECEIPT OR STATEMENT ACCOMPANIES THE BILL AT THE TIME THE CLAIM IS SUBMITTED

*** IMPORTANT: ALL INTERCOLLEGIATE SPORTS CLAIMS MUST BE SIGNED BY AN AUTHORIZED ATHLETIC/SCHOOL OFFICIAL**

I hereby certify that the above injury was sustained while participating in official activities under adequate organizational supervision

Signature of College Official _____ **Title** _____ **Date** _____ DATE

To any medical care provider, medical care facility, insurer, government-sponsored health plan, or employer: I permit (*while my claim is pending*) the release of any medical information about me to the Company and its representatives. The Company's representatives include re-insuring companies and other persons or groups performing business or legal services relating to my claim. This applies to all information about the diagnosis, treatment, or prognosis or any illness or injury I now have or have had in the past. The Company will use this information to find out if my claim is eligible. A copy of this authorization (*one or which will be given to me by the Company upon my request*) will be as valid as this one.

I certify that the above information given by me in support of this claim is true and correct.

Patient's or Authorized Representative's Signature _____ **Date** _____

If Authorized Representative, Relationship to Patient _____

STREET _____ CITY _____ STATE _____ Zip + 4 _____