



GRADUATE STUDENT ASSISTANT
MEDICAL INSURANCE - CLAIM FORM Policy # CHH0042931

Special Notice: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Section 1			
Student Name		Maiden Name	Student Identification Number (Required)
Sex Male _____ Female _____	Date of Birth	Name of Spouse	Date of Marriage
Street	Apt. Number	City	State Zip Code
Name of Patient	Sex Male _____ Female _____	Date of Birth	Relationship to Student
If the claim is for your spouse or a dependent, is your spouse or dependent living with you? Yes _____ No _____			
Is your spouse or dependent employed? Yes _____ No _____ If Yes, name and address of employer _____			

Section 2	
Is the patient covered by any other insurance coverage or health plan (including coverage under your parent's plan)? Yes _____ No _____	
If Yes, please give the name and address of the insurance company _____	
_____	Phone Number _____
Policy Number _____	Effective Date _____ Termination Date _____
Was the patient insured under a health plan immediately preceding the effective date of coverage under this plan? Yes _____ No _____	
If Yes, please give the name and address of the insurance company _____	
_____	Phone Number _____
Policy Number _____	Effective Date _____ Termination Date _____

Section 3	
What was the condition requiring treatment? _____	
Is this claim for: a New condition? _____ a Continuing condition? _____	
Has this patient received medical advice or has a Health Care Provider recommended or provided treatment for this condition, within 3 months prior to your effective date of coverage under this plan? Yes _____ No _____	
Is condition related to employment? Yes _____ No _____ If Yes, is it covered under Workers' Compensation? Yes _____ No _____	
Was this an accident? Yes _____ No _____ Date of Accident _____ Was a boat or motor vehicle involved? Yes _____ No _____	
Please give details of accident _____	
Was this injury the result of play or practice during a Sport? Yes _____ No _____ If Yes, which Sport? <input type="checkbox"/> Intramural <input type="checkbox"/> Intercollegiate <input type="checkbox"/> Other	

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 reinsuring 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 of which will be given to me by the Company upon my request) will be as valid as this one.

THE ABOVE ANSWERS ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

DATE

SIGNATURE OF STUDENT

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: This form MUST be completed and returned WITHIN 90 DAYS from the date of treatment accompanied by all bills incurred to that date.