

PROOF OF CLAIM

This form should 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

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 school official must complete PART A*.
2. The Insured's parents or guardian must complete PART B.
3. If dental charges — have statement completed on back.
4. See reverse side for important claim procedures.

TO BE COMPLETED BY A SCHOOL OFFICIAL

PART A: NOTICE OF INJURY

1. Name of School _____ School District Name _____
 School Address _____
(City) (State) (Zip)

2. Name of Insured _____ Social Security #

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3. Age _____ Grade _____ Date of Injury _____ AM PM

4. Under whose supervision? _____ Was he/she a witness? _____

5. The accident was incurred while the Insured was participating in:

INTERSCHOLASTIC SPORTS	NON-INTERSCHOLASTIC SPORTS
() Practice _____ What sport? _____	() Travel to/from school _____ () Non-school activity _____
() Game _____	() In classroom _____ () Other – Activity? _____
() Travel _____	() Physical Education _____
	() On school grounds <input type="checkbox"/> R <input type="checkbox"/> L

6. Part of the body injured _____

7. Describe in detail how and where the injury occurred _____

Reported by _____
(Signature of School Official) (Title) (Date)

TO BE COMPLETED BY A PARENT OR GUARDIAN

PART B: PARENT STATEMENT

The school is participating in a low cost insurance program that provides benefits for medical expenses not covered by other family insurance. In order for us to determine benefits, you must file a claim with your own insurance carrier and send us a copy of the Explanation of Benefits or rejection letter. The school insurance policy will pay eligible expenses not paid by your own coverage. In order to continue this plan in your school, YOUR COOPERATION is necessary. Your claim will receive prompt attention provided all questions in PART B are answered fully.

1. Parents Name _____ Relationship to Insured _____
 Address _____
(Street or Route) (City) (State) (Zip)

2. Home phone number _____

3. Father's Occupation _____ Employer _____
 Mother's Occupation _____ Employer _____

4. List your family or group coverage, please.
 Name of Insurance Company _____ Group Individual 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) (Signature of Parent or Guardian)

FOR COMPANY USE ONLY

	Form	Date
Policy Form _____	_____	_____
Date Purchased _____	_____	_____

