National Union Fire Insurance Company of Pittsburgh, Pa.

MAIL TO:
AIG, Educational Markets Mail Center
P. O. Box 26050
Overland Park, KS 66225
1-877-775-5430

CLAIM FORM

COMPLETE IN DETAIL TO ENSURE PROMPT HANDLING

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 | Policy Number | Birth Date

Insured's Name _____ _____ _____ _____
LAST NAME | FIRST NAME | M.I | INSURED'S STUDENT ID# | SUBSCRIBER ID# | PHONE

Present Address _____ _____ _____ _____
NO. AND STREET | CITY OR TOWN | STATE | ZIP + 4

Home Address _____ _____ _____ _____
NO. AND STREET | 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? ☐ Yes Insured ☐ Yes Dependent ☐ No

If yes, please check one: ☐ Group ☐ Individual ☐ 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? ☐ Yes ☐ 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:	☐ Intramural ☐ Intercollegiate ☐ Other
5. Have you previously been troubled with this condition?	☐ Yes ☐ 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?	☐ Yes If yes, attach referral to claims form. ☐ No 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

DATE

Signature of College Official _____ **Title** _____ **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