MARKEL INSURANCE COMPANY
MARKEL® A Markel Company

Return Completed form to:
Markel Insurance Company
P.O. Box 3870
Glen Allen, VA 23058
F: 804-527-7915

Tuition Refund Claim Form

Instructions for Filing a Claim
1. Part 1 must be completed by School Office.
2. Part 2 must be completed by Parent or Legal Guardian of the withdrawing student.
3. Part 3 must be completed if the withdrawal is due to a job loss or job transfer.
4. Part 4 must be completed by the attending physician, if the withdrawal is due to medical necessity

PART 1: SCHOOL INFORMATION (*To be completed by School Office*)

School: _____ **Policy #:** _____

The below named student has withdrawn from our institution for the following reason:

☐ Medical Disability ☐ Job Transfer ☐ Voluntary - describe: _____
☐ Mental/Nervous Disorder ☐ Academic ☐ Death of Student
☐ Involuntary Job Loss ☐ Disciplinary ☐ Governmental Shutdown - describe _____

Date of First Day of Current School Year: _____ (MM/DD/YYYY) Date of Last Day of Current School Year: _____ (MM/DD/YYYY)

Actual Calendar Days in School Year: _____

Date Student Enrolled: _____ (MM/DD/YYYY) Date of Student Withdrawal: _____ (MM/DD/YYYY)

Student's Grade: _____ Student's Reported Covered Fees: _____ ☐ Day Student ☐ Boarding Student

Has student completed the academic requirements for the current school year, or graduated early? ☐ Yes ☐ No

We hereby certify that the above information is correct and complete to the best of our knowledge.

Name and Title of School Official: (please print): _____

Signature of School Official: _____

Date: _____ Phone Number: _____

PART 2: STUDENT & TUITION PAYER INFORMATION

Student Name (Last, First, MI)		Sex ☐ Male ☐ Female	
Tuition Payer Name	Phone Number		
Tuition Payer's Home Address	City	State	Zip
Spouse's Name	Phone Number		
Spouse's Home Address	City	State	Zip

AUTHORIZATION FOR RELEASE OF INFORMATION

I AUTHORIZE any physician, medical care provider, hospital, clinic, medical care facility, insurance company, government-sponsored health plan, or employer having information available as to diagnosis, treatment and prognosis with respect to any illness, injury, physical or mental condition, and/or treatment for me or my minor children now or in the past, to give to Markel Insurance Company (MIC) or its legal representative, any and all such information.

I UNDERSTAND the information obtained by use of the Authorization will be used by MIC to determine eligibility for insurance and eligibility for benefits under any existing policy. Any information obtained will not be released by MIC to any person or organization EXCEPT as necessary in connection with the processing of this application, claim, or as may be otherwise lawfully required or as I may further authorize.

I KNOW that I may request a copy of this Authorization.

I AGREE that a photographic copy of this Authorization shall be valid as the original. I also AGREE this Authorization shall be valid for a period of two years from the date shown below. I may revoke this authorization at any time by written request to MIC.

Tuition Payer Signature: _____ **Date:** _____
(Student Signature, if of legal age) MM/DD/YYYY

PLEASE NOTE

In furnishing this or other claim forms fro the convenience of the claimant, the MARKEL INSURANCE COMPANY does not admit any liability or waive any rights. MARKEL INSURANCE COMPANY reserves the right to ask for other information if it is deemed necessary. All expenses incurred in connection with furnishing the necessary proof of loss are the responsibility of the covered person.

PART 3: EMPLOYER INFORMATION (*Complete only if withdrawal is due to job loss or job transfer***)**

Name of Employer: _____

Employer Address: _____

Employer Telephone: _____ Applicable To: ☐ Tuition Payer ☐ Spouse

Tuition Payer SSN: _____ Spouse SSN: _____

PART 4: ATTENDING PHYSICIAN STATEMENT

(*Complete only if withdrawal is due medical or mental/nervous disorder - To be completed by Physician***)**

Patient's Name: _____ Date of Birth: _____

1. Condition causing disability is due to the following: ☐ Accident ☐ Sickness ☐ Mental/Nervous Disorder

2. Give date symptoms first appeared, or the date accident occurred: _____ MM/DD/YY

3. Give date the patient first consulted you for this condition: _____ MM/DD/YY

4. Give date the patient last consulted you for this condition: _____ MM/DD/YY

5. Is patient still under your care for these conditions? ☐ Yes ☐ No

6. Has patient ever had the same or similar condition? ☐ Yes ☐ No

If yes, state when and describe: _____

7. Did the condition result from the use of drugs or other narcotics not prescribed by a physician? ☐ Yes ☐ No

8. Describe any other disease or infirmity affecting present condition:

_____

9. List dates of all treatment received by patient:

_____

10. Is the patient ever been, hospitalized for this condition? ☐ Yes ☐ No If Yes, give the dates of confinement in hospital. Provide name and address of hospital in which confinement occurred:

Name of Hospital: _____ Confined from _____ to _____

Hospital Address: _____

11. Have you referred the patient to another physician? ☐ Yes ☐ No If Yes, give name and address of physician: _____

12. Have you recommended this student withdraw from classes? ☐ Yes ☐ No If Yes, give the date you anticipate patient will be able to resume class: _____ MM/DD/YY

13. Describe reasons for recommending withdrawal from classes:

_____

14. Has the patient attended classes at any school, or become employed since the date of withdrawal? ☐ Yes ☐ No

If yes, give date activity began: _____ MM/DD/YY

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize Markel Insurance Company to inspect or secure copies of case history records, laboratory reports, diagnose, prognoses, and any other data covering this or other confinements and disabilities.

Physician Name (please print): _____ Date: _____

Physician Signature: _____ Date: _____

Physician Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

EMPLOYER CERTIFICATION FORM

Name of Employer: _____

Employer Address: _____

PART A: Complete if employee is no longer employed with your company

Give employee start date: _____ Give date unemployment began: _____

Give reason for unemployment: _____

Please indicate if unemployment was: ☐ Voluntary ☐ Involuntary

PART B: Complete if employee was transferred to another geographic location with your company

Give date of transfer: _____

How many miles is the new geographic locale from the employee's current job location? _____

We hereby certify that the above information is true and correct

Name of Company Official: _____ Title: _____

Signature of Company Official: _____ Date: _____

Telephone Number of Company Official: _____

FRAUD STATEMENTS

GENERAL: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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.

ALASKA: Any person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

ARIZONA: For your protection Arizona law requires the following statement to appear on this form: Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

ARKANSAS: 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.

CALIFORNIA: For your protection, California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

DELAWARE: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

DISTRICT OF COLUMBIA RESIDENTS: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

FLORIDA: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

IDAHO: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

INDIANA: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

KENTUCKY: Any person who knowingly and with intent to defraud any insurance company or other person 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.

LOUISIANA: 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.

MAINE: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

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

MINNESOTA: A person who files a claim with intent to defraud, or helps commit a fraud against an insurer, is guilty of a crime.

NEW HAMPSHIRE: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

NEW JERSEY: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NEW MEXICO: 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 civil fines and criminal penalties.

NEW YORK: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

OHIO: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

OKLAHOMA: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

OREGON: Any person who knowingly and with intent to defraud or solicit another to defraud an insurer: (1) by submitting an application, or (2) by filing a claim containing a false statement as to any material fact, may be violating state law.

PENNSYLVANIA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent act, which is a crime and subjects such person to criminal and civil penalties.

TENNESSEE: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

TEXAS: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

VIRGINIA: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

WEST VIRGINIA: 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.