

When completed, return this form to the Plan Administrator:



COMMERCIAL TRAVELERS
COLLEGE CLAIMS DIVISION
70 GENESEE STREET
UTICA, NEW YORK 13502
1-800-756-3702

Please check the correct Underwriting Company:

- Commercial Travelers Life Insurance Company
Companion Life Insurance Company
Niagara Life and Health
National Guardian Life Insurance Company

IMPORTANT: Please attach itemized bills. This form MUST be completed in full and returned to the company WITHIN 90 DAYS from the date of treatment accompanied by all itemized bills received to date.

Notice: When we are the secondary plan, we do not pay until after the primary plan has paid its benefits if any. We will review Usual & Customary charges of each plan and allow the highest.

CLAIM CANNOT BE PROCESSED WITHOUT THIS INFORMATION

Form with fields for College (or) University, Student's Name, Policy #, Gender, Date of Birth, Relationship, Street Address, City, State, Zip, Telephone.

1. Date of injury (or) onset of sickness... When was physician first consulted?
Nature of illness (or) injury... Part of Body Injured: Right Left
If injury, (a) How and where did accident occur?

(b) Were you practicing or playing any intercollegiate (between rival colleges) sport at the time of the accident?
Club Sport? Yes No If "Yes," name sport

(c) IF AN INTERCOLLEGIATE ACCIDENT, THIS FORM MUST BE SIGNED BY THE ATHLETIC DEPARTMENT

I certify the above accident resulted from the supervised practice or play or travel to and from an intercollegiate sport.

Signature of Athletic Department Official Title Date

2. Were you treated and/or referred by the Student Health Service? Yes No If "Yes," date

3. Hospital (Give name, address and date of confinement) From / / To / /

4. Give names, addresses and telephone numbers of all attending physicians Phone

5. Give name, address and telephone number of usual family physician Phone

6. Have you suffered same or similar condition in the past? Yes No If "Yes," and you were treated for it, please give name and address of the physician who treated you
Dates treated
If hospitalized at that time: Name of hospital
Address Dates Confined

7. Was injury the result of a motor vehicle accident? Yes No

8. Are you employed full-time? Yes No If yes, Employers Name
Employers Address Employers Phone Number

9. Name of Parent #1 SS # Father's Employer-Name Address Employer's Phone #

10. Name of Parent #2 SS # Mother's Employer-Name Address Employer's Phone #

11. Spouse's Name SS # Spouse's Employer-Name Address Employer's Phone #

12. Do you, your spouse or your parents have other insurance or medical plan which covers this condition, either group, individual, automobile, medical or liability?
Yes No If so, give name of Company:

I hereby authorize any physician, hospital, company, employer, or organization to release any information regarding the medical history, treatment, or benefits payable for this claim, to the Insurance Company checked above or its authorized benefit plan administrator.

I also authorize the Insurance Company checked above or their representatives to pay all bills in connection with this claim directly to the doctor, hospital or any other persons rendering service, and such payment shall release the Insurance Company from liability as to amounts so paid.

FOR RESIDENTS OF ALL STATES OTHER THAN THOSE LISTED ON PAGE 2: Any person who knowingly, and with intent to defraud, injure or deceive any insurance company, files or causes to be filed, a claim for payment of a loss, containing any false or incomplete information commits a fraudulent insurance act that may be a crime and may subject such person to confinement in prison, fines and denial of benefits.

I hereby CERTIFY that I have read the answers to all parts of this form and to the best of my knowledge and belief the information is complete and correct as given herein.

Name of student Date

Signature of claimant (parent or guardian if not adult)

Student's Address While at School Street City State Zip

AK, CT, DE, HI, IA, ID, IL, IN, MI, MN, MO, MT, MS, NC, ND, NV, SC, SD, UT, WI & WY: Any person who knowingly and with intent to defraud an insurer submits a written application or claim containing any materially false or misleading information is guilty of insurance fraud.

AL, AR, DC, LA, MA, and RI: 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.

AZ: 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.

CA: 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.

CO: 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."

FL: 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.

GA, NE, KS, OR, TX, VT: Any person who knowingly and with intent to defraud an insurer submits a written application or claim containing any materially false or misleading information may be guilty of insurance fraud.

KY: 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 commits a fraudulent insurance act, which is a crime.

ME: 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.

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

NH: 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.

NJ: Any person who includes any false or misleading information on an application or statement of claim for an insurance policy is subject to criminal and civil penalties.

NM: 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.

NY: Any person who knowingly and with intent to defraud any insurance company or other person files an application for health insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, any 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 \$5,000.00 and the stated value of the claim for each such violation.

OH: 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.

PA: 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 subjects such person to criminal and civil penalties.

OK: 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.

TN: 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.

VA, WA: 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 or a denial of insurance benefits.

WV: 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.