UNITED STATES FIRE INSURANCE COMPANY

By Fairmont Specialty, a Division of Crum & Forster
Eatontown, New Jersey

ACCIDENT CLAIM FORM
HOW TO FILE YOUR CLAIM

1. **Initial treatment must be made within 30 days of injury.**
2. **Attach itemized bills and Explanation of Benefits from your other insurance carrier.**
3. **Mail to: T.W. LORD & ASSOCIATES**
   P.O. Box 1185
   Marietta, GA 30061

IMPORTANT NOTICE

Your student insurance plan is designed to provide maximum benefits for a minimum premium. It will not duplicate benefits paid or payable by other insurance. If your claim is over $100 and you have other medical insurance, submit your claim to your other insurance company first. When you receive their Explanation of Benefit Statement, send it to us. We will pay benefits for those eligible expenses not paid by your other insurance. If your medical bills are under $100, benefits are paid regardless of whether you have other insurance.

PART 1-A: SCHOOL AND PARENT

(1) School District:_____ (2) School:_____
(3) School Address:_____ (4) School Phone #_____
(5) Student:_____ (6) Student's Social Security #_____
(Last Name) (First Name)
Male____
(7) Grade:_____ (8) Birth Date: _____ (9) Female____ (10) Date of Injury_____(11) Time_____
(12) Where did injury occur?_____(13) Date of first treatment?_____
(14) How did injury occur? (Give all possible details)
_____
(15) Part of body injured_____ (16) Type of Sport_____
(17) At the time of injury was the student involved in a school sponsored & supervised activity? _____Yes _____No
(18) If athletics, designate: _____ P.E. Class _____ Intramural _____ Interscholastic _____Practice _____Game
(19) Under whose supervision?_____ Was he/she a witness? ____Yes ____No
(20) Signature: X_____ Title:_____ Date:_____
(must be signed by school official unless injury did not occur during a school activity)

PART 1-B: PARENT OR GUARDIAN STATEMENT

(1) Student's Social Security #_____ (2) Date of first treatment?_____
(3) Father's Name_____ Social Security #_____
(4) Mother's Name_____ Social Security #_____
(5) Home Address_____
(Street) (City) (State) (Zip) (Home Phone No.)
(6) Father's Employer_____ Business Phone No._____
(7) Employer's Address_____
(8) Name and Address of other Insurance Company_____
(9) Policy No._____ ____Group ____ Individual ____Other _____No Other Insurance
(10) Mother's Employer_____
(11) Employer's Address_____ Business Phone No._____
(12) Name and Address of other Insurance Company_____
(13) Policy No._____ ____Group _____Individual ____Other _____No Other Insurance

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.

PAYMENT WILL BE MADE 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.

AUTHORIZATION TO OBTAIN MEDICAL INFORMATION

Any medical professional, hospital or other medical-care institution, insurance support organization, pharmacy, governmental agency, insurance company, group policyholder or benefit plan administrator. I AUTHORIZE you to release to the UNITED STATES FIRE INSURANCE COMPANY or its representatives, PROFESSIONAL CLAIMS ADMINISTRATORS, INC. any and all information concerning advice, care or treatment provided the patient, or deceased, including information relating to mental illness, use of drugs or use of alcohol. I also authorize the group policyholder or benefits plan administrator to provide to the UNITED STATES FIRE INSURANCE COMPANY or its Representatives, PROFESSIONAL CLAIMS ADMINISTRATORS, INC. with insurance coverage information including benefits paid or payable, financial information or employment related information. I UNDERSTAND that the information released under this authorization will be used for the purpose of evaluating and processing a claim for benefits. I authorize the UNITED STATES FIRE INSURANCE COMPANY, or its representatives, PROFESSIONAL CLAIMS ADMINISTRATORS, INC. to disclose the information for that purpose to the group policyholder or its representatives, to any reinsurer, and to any other insurer or self-insurer to whom a claim for benefits may be submitted. This disclosure will include benefits paid or copies of checks/drafts. I also AUTHORIZE the UNITED STATES FIRE INSURANCE COMPANY, or its representatives, PROFESSIONAL CLAIMS ADMINISTRATORS, INC. to disclose the information to any person performing a business or legal function for its benefit, and to any person who has an authorization specifically permitting the disclosure.I AGREE that the authorization shall be valid from the date signed for one full year. I know that I have a right to request to receive a copy of this authorization. A photocopy of this authorization shall be as valid as the original.

_____ _____
Parent or Authorized Representative's Signature **Date Signed**