

COVERAGE VERIFIED

**PLEASE PRINT ALL
INFORMATION**

SPECIAL NOTICE: 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.

PART 1 – MUST BE COMPLETED AND SIGNED

Name of School OHIO CHRISTIAN UNIVERSITY	Policy Number CHH0077261	Birth Date
Insured's Name	INSURED'S STUDENT ID #	PHONE
Present Address	CITY OR TOWN	STATE ZIP + 4
Home Address	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? <input type="checkbox"/> Yes Insured <input type="checkbox"/> Yes Dependent <input type="checkbox"/> No
	If yes, please check one: <input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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:	<input type="checkbox"/> Intramural <input type="checkbox"/> Intercollegiate <input type="checkbox"/> Other
5. Have you previously been troubled with this condition?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, attach referral to claims form. 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

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 of 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
--------	------	-------	---------