KNOX COLLEGE STUDENT ACCIDENT INSURANCE CLAIM REPORT

To be eligible for policy benefits, TREATMENT BY A LICENSED PHYSICIAN MUST BE RENDERED WITHIN 90 DAYS FROM THE DATE OF ACCIDENT.
Mail this claim report to: **Lawrence E. Smith & Associates, Inc. P.O. Box 411216 St. Louis, MO. 63141 or FAX to 636-532-1737**
Phone 800 325-1350

IMPORTANT NOTICE: The Knox College insurance policy is designed to supplement, not replace or duplicate, any other insurance that you may have in effect. Therefore, before you can collect benefits from the College policy, you must first file a claim and determine what benefits will be paid under any other insurance through you parent's primary insurance or other source of coverage. Forward a copy of itemized medical bills along with this claim form and a copy of the statement received from you parent's or other primary insurance showing what the other insurance company paid or the reason why they declined to pay any bills that you submitted.

Student _____
(First name) (Last Name)

Birth date _____ Date of Accident_____ Time of accident _____

Student's mailing address:_____

Where did the accident happen? _____

Was the injury caused during a Knox College intercollegiate sports practice or game? Yes_____ No _____

If Yes, Name of Coach: _____ Was he/she a witness to accident? ☐ Yes ☐ No

Specifically – what happened that caused the injury? Please be detailed and specific.

_____

_____

Part (s) of the body injured in the accident: _____

The following information is needed to verify parent's insurance information:

Do you understand that you must furnish, with this claim, a statement from your insurance company indicating their allowable benefits or their reason for refusal to pay? Your claim will be held pending receipt of this information. ☐ Yes ☐ No

Father's Name_____

Mother's Name _____

Home Address _____
(Street/P.O. Box) (City) (State) (Zip) (Home Phone No.)

Father's Occupation _____ Employer _____Tel.#_____

Employer's Address _____

Name and Address of Insurance Company _____

Policy No._____ ☐ Group ☐ Individual ☐ Other ☐ No other insurance

Mother's Occupation _____ Employer _____Tel# _____

Employer's Address _____

Name and Address of Insurance Company _____

Policy No. _____ Group ☐ Individual ☐ Other ☐ No other insurance

REQUIRED STATEMENT: 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. **AFFIDAVIT:** *I certify that the above information is true and correct. I AUTHORIZE any doctor, medical practitioner, hospital, clinic, other medical or medically related facility or insurance company, or other organization, institution, or person that has any record or knowledge of: a) the claimant's physical health or: b) other benefits for which the claimant may be entitled to for this claim; to give the information to the insurance company to facilitate rapid submission for such information. I authorize all said sources, to give such records or knowledge to any agency employed by the insurance company to collect and transmit such information. I understand that false or incomplete information will prolong claim benefit determination. A photocopy of this authorization shall be as valid as the original.*

SIGNATURE_____ Date_____
(Knox College injured student's signature)

knoxclm-2012(1)

ATTENDING PHYSICIAN'S STATEMENT

1. Diagnosis and concurrent conditions. Describe any complications.

2. When did symptoms first appear or accident happen? Date _____

3. When did patient first consult you for this condition? Date _____

4. Has patient ever had same or similar condition? If yes, state when and describe. No ☐ Yes ☐ Date_____

5. Describe any other disease or infirmity affecting present condition.

6. If fracture or dislocation, state whether reduced or immobilized. If immobilized, explain procedure. Fee $ _____
   CPT/CRVS _____

7. Name of surgical procedure. Describe fully. Include CPT/CRVS Code. Where and when performed? Fee $_____
   CPT/CRVS _____ Date _____ Office ☐ If in hospital, inpatient ☐ outpatient ☐

8. Give dates of other medical (non-surgical) treatment, if any. Describe. CHARGE PER CALL
   Office _____ $ _____
   Office _____ $ _____
   Hospital _____ $ _____
   Hospital _____ $ _____
   TOTAL (NON SURGICAL) CHARGES $ _____

9. If patient hospitalized, give name and address of hospital. Date admitted _____ Date discharged _____
   Hospital _____ City _____ State _____

10. To your knowledge does patient have other health insurance or health plan coverage? If "Yes", identify. No ☐ Yes ☐
    Name _____Address _____

If Dentistry, answer all questions below, in addition to those above.

1. State exactly which teeth were involved in the accident and indicate them on chart.
   _____
2. Describe exact nature of injury _____
3. Describe condition of injured teeth prior to accident:
   ☐ Whole, sound and natural ☐ Filled ☐ Capped/Artificial ☐ Caries
4. Comments _____

Physician or Supplier's Name	Degree
Street Address	TIN #
City / State / Zip	Date
Telephone	Signature

IMPORTANT: This form MUST be completed and returned WITHIN 90 DAYS from the date of treatment, accompanied by **ITEMIZED** bills.

The Knox College Accident Insurance Policy is underwritten by Reliance Standard Life Insurance Co.: Home office Philadelphia, PA
All claims are processed by **Lawrence E. Smith & Associates, Inc. P.O. Box 411216 St. Louis, MO 63141**
FAX 636-532-1737
PHONE 800-325-1350