

KNOX COLLEGE STUDENT ACCIDENT INSURANCE CLAIM FORM

EMAIL, FAX, OR MAIL this completed form to:

Lawrence E. Smith & Associates, TPA

Mail To: P.O. Box 411216 St. Louis, M O 63141 <> Fax 636-532-1737 <> Email lucyw@lesmith.net

Important Notice: The student insurance plan provides specified benefits for covered medical services that are not collectible from other insurance or other primary sources of coverage. To be eligible to receive policy benefits, you must first file a claim with any other insurance or source of coverage and attach a statement from any other insurance or source of coverage indicating what benefits are payable or not payable. The Knox College Student Accident Insurance plan may not cover all medical treatment expenses. Students are ultimately responsible for paying for all medical bills not covered by the Knox College Student Insurance Plan.

Student's Name _____ Age _____

Address _____
Street/P.O. Box _____ City _____ Zip Code _____

Are you a full-time degree seeking student at Knox College? YES NO

Date of accident _____

Description of injury (fracture, laceration, sprain, arm, leg, other) _____

Describe fully how, when and where accident occurred _____

Have you previously been troubled with this condition?
NO YES If yes, please describe previous condition and date of prior condition _____

Do you have other insurance through your parent's insurance plan or any other source of coverage?
NO YES If yes, provide the name and address of insurance company:
Name of Company: _____
Address: _____
Telephone No.: _____
Policy No.: _____

THIS FORM MUST BE COMPLETED AND RETURNED WITHIN 90 DAYS FROM THE COMPLETION OF TREATMENT. ATTACH COPIES OF ALL ITEMIZED MEDICAL BILLS TO THIS FORM AND A STATEMENT FROM ANY OTHER INSURANCE COMPANY INDICATING THEIR PAYMENT OR DENIAL OF BENEFITS. THE STUDENT INSURANCE POLICY BENEFIT CHECKS WILL BE MAILED TO DOCTORS AND HOSPITALS UNLESS YOU ENCLOSE A STATEMENT FROM THE DOCTOR OR HOSPITAL VERIFYING THAT THEY RECEIVED PAYMENT DIRECTLY FROM YOU. A COPY OF BILLS PAID BY THE STUDENT INSURANCE COMPANY WILL BE SENT TO YOU. STUDENTS ARE RESPONSIBLE FOR PAYMENT OF ALL MEDICAL SERVICES THAT ARE NOT COVERED BY THE KNOX STUDENT INSURANCE PLAN.

AUTHORIZATION: I hereby authorize Lawrence E. Smith & Associates, TPA or its representatives, to inspect or secure copies of case history records, doctor's and hospital reports, diagnosis, prognosis, X-rays, and any other data regarding treatment of the undersigned claim. A photostatic copy of this authorization shall be deemed as effective and valid as the original.

SIGNATURE: _____ DATE: _____