KNOX COLLEGE STUDENT INSURANCE CLAIM FORM

STUDENT'S STATEMENT

This form must be returned to:
KidGuard Insurance
P. O. Box 784268, Winter Garden, FL 34778
Phone: (800) 432-6915 Fax: (407) 798-0296

***Important Notice*:** The student insurance plan is designed to offer maximum financial protection at a minimum cost. To maintain this balance of cost and adequate protection, the plan does not allow us to provide benefits for certain losses that are collectible from other insurance. This provision has greatly reduced the cost to you by not duplicating coverage that you already have in effect. Please attach a statement from your insurance company indicating what benefits are available and complete the following questions.

Student's Name _____ Age _____ Social Security Number _____

Address _____
Street\P.O. Box City State Zip

If claim is for a dependent, give name, relationship, and age: _____
Name Relationship Age

Date of injury or beginning of sickness	
Nature of injury or sickness	
If injury, describe fully how and where accident occurred	
Have you previously been troubled with this condition?	No [ ] Yes [ ] If yes, give details.
Name and address of Physician	
Give names of all other physicians consulted	
Hospitalized	From: __/__/__ To: __/__/
Name and address of Hospital	
Has treatment been completed?	No [ ] Yes [ ] If no, give details.
Do you have other insurance which covers this condition, either group, individual, automobile, medical or liability?	No [ ] Yes [ ] If yes, give name and address of company: Name of Company: _____ Address: _____ Telephone No.: _____ Policy No.: _____

THIS FORM MUST BE COMPLETED AND RETURNED WITHIN 90 DAYS OF THE COMPLETION OF TREATMENT.
Itemized bills for hospital expense or medical treatment must be submitted showing dates of service or treatment.
ASSIGNMENT OF BENEFITS IS AUTOMATICALLY MADE UNLESS PAID RECEIPTED BILLS ARE ENCLOSED.

AUTHORIZATION: I hereby authorize KidGuard Insurance or its representatives, to inspect or secure copies of case history records, laboratory reports, diagnosis, prognosis, X-rays, and any other data covering this confinement and/or disability. A photostatic copy of this authorization shall be deemed as effective and valid as the original.

SIGNATURE: _____ DATE: _____