

**Plan Administered by:**



COMMERCIAL TRAVELERS  
70 GENESEE STREET  
COMMERCIAL TRAVELERS BUILDING  
UTICA, NEW YORK 13502  
1-800-756-3702

**When completed, return this form to:**

T.L. GROSECLOSE ASSOCIATES, INC.  
190 TAMARACK CIRCLE  
SKILLMAN, NJ 08558  
PHONE (609) 279-1507 FAX (609) 279-1535



**Please check the correct Underwriting Company:**

- Commercial Travelers Mutual Insurance Company
- Fidelity Security Life Insurance Company
- Security Mutual Life Insurance Company

**IMPORTANT: This form MUST be completed in full and returned to the company WITHIN 90 DAYS from the date of treatment accompanied by all itemized bills received to date. Mail to the address shown on this form. Payments will be made to the service provider.**

**CLAIM CANNOT BE PROCESSED WITHOUT THIS INFORMATION**

College (or) University _____		<input type="checkbox"/> Domestic Student—Soc. Sec. # _____			
		<input type="checkbox"/> International Student—Student ID # _____			
Student's Name _____		Policy # _____	<input type="checkbox"/> Male <input type="checkbox"/> Female		Date of Birth _____
If Claim for Dependent Give Name and Relationship	Name _____	Relationship _____	<input type="checkbox"/> Male <input type="checkbox"/> Female		Date of Birth _____
Student Mailing Address	Street Address _____	City _____	State _____	Zip _____	Telephone (     ) _____

1. Date of injury (or) onset of sickness \_\_\_\_\_ When was physician first consulted? \_\_\_\_\_  
 Nature of illness (or) injury \_\_\_\_\_  
 If injury, (a) How and where did accident occur? \_\_\_\_\_

(b) Were you practicing or playing any intercollegiate (between rival colleges) sport at the time of the accident?  Yes  No  
 Club Sport?  Yes  No If "Yes," name sport \_\_\_\_\_

(c) IF AN INTERCOLLEGIATE ACCIDENT, THIS FORM MUST BE SIGNED BY THE ATHLETIC DEPARTMENT  
 I certify the above accident resulted from the supervised practice or play or travel to and from an intercollegiate sport.

Signature of Athletic Department Official \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_

2. Were you treated and/or referred by the Student Health Service?  Yes  No If "Yes," date \_\_\_\_\_

3. Hospital (Give name, address and date of confinement) \_\_\_\_\_  
 \_\_\_\_\_ From / / To / /

4. Give names, addresses and telephone numbers of all attending physicians \_\_\_\_\_  
 \_\_\_\_\_ Phone \_\_\_\_\_

5. Give name, address and telephone number of usual family physician \_\_\_\_\_  
 \_\_\_\_\_ Phone \_\_\_\_\_

6. Have you suffered same or similar condition in the past?  Yes  No If "Yes," and you were treated for it, please give name and address of the physician who treated you \_\_\_\_\_

Dates treated \_\_\_\_\_

If hospitalized at that time: Name of hospital \_\_\_\_\_

Address \_\_\_\_\_ Dates Confined \_\_\_\_\_

7. Was injury the result of a motor vehicle accident?  Yes  No

8. Are you employed full-time?  Yes  No If yes, Employers Name \_\_\_\_\_

Employers Address \_\_\_\_\_ Employers Phone Number \_\_\_\_\_

9. \_\_\_\_\_  
 Father's Name SS# Father's Employer-Name Address Employer's Phone #

10. \_\_\_\_\_  
 Mother's Name SS# Mother's Employer-Name Address Employer's Phone #

11. \_\_\_\_\_  
 Spouse's Name SS# Spouse's Employer-Name Address Employer's Phone #

12. Do you, your spouse or your parents have other insurance or medical plan which covers this condition, either group, individual, automobile, medical or liability?  
 Yes  No If so, give name of Company: \_\_\_\_\_

I hereby authorize any physician, hospital, company, employer, or organization to release any information regarding the medical history, treatment, or benefits payable for this claim, to the Insurance Company checked above or its authorized benefit plan administrator. A photostatic copy of this authorization shall be as valid as the original.

I also authorize the Insurance Company checked above or their representatives to pay all bills in connection with this claim directly to the doctor, hospital or any other persons rendering service, and such payment shall release the Insurance Company from liability as to amounts so paid.

**Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime (in FL, a felony in the third degree), and in the state of New York, shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.**

I hereby CERTIFY that I have read the answers to all parts of this form and to the best of my knowledge and belief the information is complete and correct as given herein.

Name of student \_\_\_\_\_ Date \_\_\_\_\_

Signature of claimant (parent or guardian if not adult) \_\_\_\_\_

Student's Address While at School \_\_\_\_\_  
 \_\_\_\_\_ Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_