Global
CLAIMS ADMINISTRATION

Member of the Global Group of Companies
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800-513-2981
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Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person submits an insurance application or statement of claim containing any materially false, incomplete or misleading information may be committing a crime and may be subject to civil or criminal penalties.

Please Print All Information

MUST BE COMPLETED AND SIGNED BY STUDENT/INSURED or Authorized Representative

Name of College, University or Group, City and State _____

Policy Number ***US022304***

Birth Date _____

Student ID# _____

Phone # _____

Student/Insured Name_____
Last Name First Name M.I.

Present Address_____

Home Address_____

If claim is for dependent, dependent's name_____, relationship to insured_____

COMPLETE THIS SECTION FOR ACCIDENT CLAIM

Exact nature of injury_____

_____

Date of occurrence_____

_____

Was this injury due to practice or play of a sport? ___Yes ___No

Which Sport? _____

____Intercollegiate ___Intramural ___Club ___Other

Is condition work related? ___Yes ___No
Is condition due to auto accident? ___Yes ___No

If yes, please attach detailed policy information on all motor vehicles involved in accident.

COMPLETE THIS SECTION FOR SICKNESS CLAIM

Date of Sickness_____

Date symptoms first noticed_____

If pregnancy, date of last menstrual period_____

What is the exact nature of the sickness? _____

_____

_____

Have you ever had the same or similar condition? __Yes __No

If yes, date of first treatment _____
Date of last treatment _____

Were you treated in the Health Service for this condition?
___Yes ___No

**Do you have <u>any other insurance</u>? ___Yes ___No *If yes, please give name and address of insurance company on the line below

_____

Global Claims Administration, LLC does not share private health information except as required or permitted by law.
We are committed to guarding the private information entrusted to us.

PAYMENT WILL BE MADE TO THE PROVIDERS OF SERVICE, UNLESS A PAID RECEIPT IS ATTACHED AT TIME OF SUBMISSION.

To any medical care provider, medical care facility, Insurer, government-sponsored health plan, or employer; I authorize the release of any medical information about me to Global Claims Administration, LLC or US Fire Insurance Co. 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. Global Claims Administration, LLC will use this information to determine if my claim is eligible. Any information obtained will not be released by Global Claims Administration, LLC except to my primary health insurance carrier (if any) or persons or organizations performing investigative legal services for Global Claims Administration, LLC in connection with my claim. A copy of this authorization shall be considered as effective and valid as the original and shall remain in effect for one year from the date of authorization. I <u>certify that the information given by me in support of my claim is true and correct.</u>

Patient's or Authorized Representative's Signature _____ Date _____

If Authorized Representative, Relationship to Patient _____

Or Legal Designation _____