CLM #

PLAN	PAY

DATE PREM. PD. _____

AMOUNT PD. _____

THIS SPACE FOR COMPANY USE ONLY

NAME OF SCHOOL _____

ADDRESS _____

POLICY NO _____

IMPORTANT!
THIS INFORMATION MUST BE GIVEN OR CLAIM WILL BE RETURNED

Guarantee Trust Life Ins. Co. administered by FIRST AGENCY
5071 West H Avenue
Kalamazoo, MI 49009-8501
Phone (269) 381-6630 - Fax (269) 381-3055

PARENTS/GUARDIAN TO COMPLETE IN ORDER FOR CLAIM TO BE PROCESSED

Father's Full Name _____

Home Address _____

City _____ State _____ Zip _____

Home Phone _____

Employer Name _____

Employer Address _____

City _____ State _____ Zip _____

PLEASE COMPLETE THE FOLLOWING SECTION EVEN IF NO BENEFITS ARE PROVIDED:

Do you have insurance? ☐ YES ☐ NO

Is this student covered? ☐ YES ☐ NO

Name of Insurance Plan _____

Social Security Number _____

Phone Number _____ Group Number _____

If you are employed, but your dependent is not covered under your employer's plan, a letter to this effect from your employer is required.

Mother's Full Name _____

Home Address _____

City _____ State _____ Zip _____

Home Phone _____

Employer Name _____

Employer Address _____

City _____ State _____ Zip _____

PLEASE COMPLETE THE FOLLOWING SECTION EVEN IF NO BENEFITS ARE PROVIDED:

Do you have insurance? ☐ YES ☐ NO

Is this student covered? ☐ YES ☐ NO

Name of Insurance Plan _____

Social Security Number _____

Phone Number _____ Group Number _____

If you are employed, but your dependent is not covered under your employer's plan, a letter to this effect from your employer is required.

ASSIGNMENT OF BENEFITS:

I hereby authorize The Guarantee Trust Life Insurance Company to pay bills in connection with this accident directly to the Doctor, Hospital or Other Payee.

DATE _____ SIGNATURE OF PARENT OR GUARDIAN _____

(Claimant if an ADULT)

SCHOOL OFFICIAL TO COMPLETE - (PLEASE PRINT, (PARENT/GUARDIAN MUST COMPLETE IF 24-HOUR COVERAGE CLAIM IS INVOLVED)

Claimant's FULL NAME _____ S.S. # _____ DATE OF BIRTH _____

Claimant's Address _____

(Street or RFD) (City) (State) (Zip)

Date of Accident: _____ Hour _____ (Check One) ☐ A.M. ☐ P.M. Grade _____

Description of Accident: How and where did it occur? _____

(If more space is needed, attach separate sheet)

Description of Activity (What was Claimant doing at time of Accident?) _____

If Athletics - name sport _____ (Check One) ☐ Intramural ☐ Interscholastic ☐ Other

Part of Body Injured: _____ ☐ Right ☐ Left

On date of Accident what time did school start for this student? _____ What time was student dismissed from school? _____

Has previous claim been filed for this accident: ☐ Yes ☐ No

A. Name of School Authority supervising Activity: _____

B. Was Supervisor a witness? ☐ Yes ☐ No If not, when was Accident first reported to School Authority? _____

I certify that the above information is correct to the best of my knowledge and belief.

Date of this report _____ Signature of School Official _____ Title _____

Any person who knowingly and with intent to defraud an insurer presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to civil fines and criminal penalties.

(MN)

FOR AUTHORIZATION SIGNATURE PLEASE SEE OTHER SIDE.

FIRST AGENCY
GUARANTEE TRUST LIFE INSURANCE COMPANY
5071 WEST H AVENUE, KALAMAZOO, MI 49009-8501
1-269-381-6630

AUTHORIZATION

To Permit Use and Disclosure of Health Information

This Authorization was prepared by First Agency for purposes of obtaining information necessary to process a claim for benefits.

Upon presentation of the original or a photocopy of this signed Authorization, I authorize, without restriction (except psychotherapy notes), any licensed physician, medical professional, hospital or other medical-care institution, insurance support organization, pharmacy, governmental agency, insurance company, group policyholder, employer or benefit plan administrator to provide First Agency or an agent, attorney, consumer reporting agency or independent administrator, acting on it's behalf, all information concerning advice, care or treatment provided the patient, employee or deceased named below, including all information relating to, mental illness, use of drugs or use of alcohol. This Authorization also includes information provided to any affiliated insurance company on previous applications. If this Authorization is for someone other than myself, that individual and my authority to act on their behalf is explained below.

I understand that I have the right to revoke this Authorization, in writing, at any time by sending written notification to my agent or to the Company at the above address. I understand that a revocation will not be effective to the extent the Company has relied on the use or disclosure of the protected health information or if my Authorization was obtained as a condition to determine my eligibility for benefits. Revocation requests must be sent in writing to the attention of the Claim Department Manager.

I understand that First Agency may condition payment of a claim upon my signing this Authorization, if the disclosure of information is necessary to determine the level or validity of the claim payment. I also understand once information is disclosed to us pursuant to this Authorization, the information will remain protected by First Agency in accordance with federal or state law.

This Authorization is valid from the date signed for the duration of the claim.

I understand that I or my authorized representative is entitled to receive a copy of this authorization upon request.

_____

(Please Print) Name of Patient

_____ _____

Signature of Patient if claimant is 18 or older — Date

_____

(Please Print) Name of Authorized Representative, or Next of Kin

_____

Relationship of Authorized Representative or Next of Kin to Patient

_____ _____

Signature of Authorized Representative or Next of Kin — Date