Claim Serial Number (for office use only)

Guarantee Trust Life Ins. Co.
administered by
First Agency
5071 West H Avenue
Kalamazoo, MI 49009-8501

ACCIDENT CLAIM FORM

PARENT/GUARDIAN TO COMPLETE
ALL INFORMATION MUST BE COMPLETE OR CLAIM CANNOT BE PROCESSED

Student's Full Name _____ Exact Date of Accident _____

Student's Date of Birth _____

FATHER	MOTHER
Father's Full Name _____	Mother's Full Name _____
Home Address _____	Home Address _____
City _____ State _____ Zip _____	City _____ State _____ Zip _____
Home Phone _____	Home Phone _____
Employer Name _____	Employer Name _____
Employer Address _____	Employer Address _____
City _____ State _____ Zip _____	City _____ State _____ Zip _____
Self Employed? ☐ YES ☐ NO	Self Employed? ☐ YES ☐ NO
PLEASE COMPLETE THE FOLLOWING SECTION EVEN IF NO BENEFITS ARE PROVIDED:	PLEASE COMPLETE THE FOLLOWING SECTION EVEN IF NO BENEFITS ARE PROVIDED:
Do you have insurance? ☐ YES ☐ NO Is this student covered? ☐ YES ☐ NO	Do you have insurance? ☐ YES ☐ NO Is this student covered? ☐ YES ☐ NO
Name of Insurance Plan _____	Name of Insurance Plan _____
Phone Number _____	Phone Number _____
Group 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.	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.

AUTHORIZATION - To Permit Use and Disclosure of Health Information

First Agency
5071 West H Avenue
Kalamazoo, MI 49009-8501

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 its 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 medical or health information may include information on the diagnosis, treatment and testing results related to HIV, AIDS, and sexually transmitted diseases, unless otherwise restricted by state law. This Authorization also includes information provided to our health division for underwriting or claim servicing and information provided to any affiliated insurance company on previous applications. If this Authorization is for someone other than myself, that individual has given me the authority to act on his/her behalf as 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 us at the above address. I understand that a revocation will not be effective to the extent we have 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 Claims Supervisor.

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.

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

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

_____
Name of Authorized Representative, or Next of Kin

_____
Name of Claimant

_____ _____
Signature of Authorized Representative or Next of Kin Date

_____ _____
Signature of Claimant (If claimant is 18 or older) Date

_____
Relationship of Authorized Representative or Next of Kin to Claimant

SCHOOL/ADMINISTRATOR/OFFICIAL/POLICYHOLDER TO COMPLETE

School Student Attends _____ in _____ School District

Student's Full Name (Last, First, MI): _____ Sex: ☐ Male ☐ Female Grade: _____

Student's Home Address: _____

Date of Accident: _____ Time of Accident: _____ ☐ AM ☐ PM

Detailed Description of Accident: How did it occur? (or attach accident report completed by the school representative who witnessed the accident) _____

Where did it occur? _____

Part of body injured: _____ ☐ Right ☐ Left

Activity: _____ ☐ Interscholastic ☐ Intramural ☐ Club ☐ Other (describe) _____

Name of school authority supervising activity: _____

Was supervisor a witness to the accident? ☐ Yes ☐ No If No, date reported to school: _____

Signature of School Official: _____ Date: _____ Title of School Official: _____