



Claim Serial Number (for office use only)  
\_\_\_\_\_

# 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 Social Security Number \_\_\_\_\_ 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? <input type="checkbox"/> YES <input type="checkbox"/> NO	Self Employed? <input type="checkbox"/> YES <input type="checkbox"/> NO
<b>PLEASE COMPLETE THE FOLLOWING SECTION EVEN IF NO BENEFITS ARE PROVIDED:</b>	<b>PLEASE COMPLETE THE FOLLOWING SECTION EVEN IF NO BENEFITS ARE PROVIDED:</b>
Do you have insurance? <input type="checkbox"/> YES <input type="checkbox"/> NO Is this student covered? <input type="checkbox"/> YES <input type="checkbox"/> NO	Do you have insurance? <input type="checkbox"/> YES <input type="checkbox"/> NO Is this student covered? <input type="checkbox"/> YES <input type="checkbox"/> NO
Name of Insurance Plan _____	Name of Insurance Plan _____
Social Security Number _____	Social Security Number _____
Phone Number _____ Group Number _____	Phone Number _____ Group Number _____
<b>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.</b>	<b>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.</b>

## AUTHORIZATION - To Permit Use and Disclosure of Health Information



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

This Authorization was prepared by First Agency, Inc. 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, Inc. 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 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, Inc. 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, Inc. 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: \_\_\_\_\_