

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, INC.**

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, INC.**  
**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, 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. (FAI) 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, 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 FAI 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.

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(Please Print) Name of Patient

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Signature of Patient if claimant is 18 or older

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Date

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

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Relationship of Authorized Representative or Next of Kin to Patient

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Signature of Authorized Representative or Next of Kin

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Date