



1. Complete this form
2. Attach all bills
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myers • stevens & toohey & co., inc.
 26101 marguerite parkway
 mission viejo, california 92692-3203
 (949) 348-0656 • fax (949) 348-2630

COLLEGE CLAIM FORM

PLEASE PRINT OR TYPE CLEARLY

Beech Street Corporation

CLAIM FORMS MUST BE FILED WITHIN 90 DAYS AFTER THE DATE OF INJURY OR FIRST TREATMENT FOR SICKNESS

NAME OF SCHOOL
ADDRESS

FOR COMPANY USE ONLY

DISTRICT NUMBER	
EFFECTIVE DATE	COVERAGE CODE

TO BE COMPLETED FOR SCHOOL SPONSORED ACTIVITIES

NAME OF SUPERVISOR / COLLEGE OFFICIAL	TITLE	WAS SCHOOL IN SESSION AT TIME OF INJURY? <input type="checkbox"/> YES <input type="checkbox"/> NO	WAS INJURY WITNESSED BY SCHOOL OFFICIALS? <input type="checkbox"/> YES <input type="checkbox"/> NO
SIGNATURE	DATE	IF YES, NAME & PHONE NUMBER	

STATEMENT OF CLAIMANT

CLASS: FR. SOPH. JR. SR. OTHER

NAME OF STUDENT	SOCIAL SEC. NO.	CLAIMANT PHONE NO.	BIRTH DATE
NAME OF PATIENT (IF OTHER THAN STUDENT)	RELATIONSHIP	BIRTH DATE	
STUDENT'S ADDRESS	STREET	CITY	STATE ZIP CODE

1 DATE OF INJURY OR BEGINNING OF SICKNESS	2 NATURE OF INJURY OR SICKNESS
DATE TIME	

3 IF INJURY, DESCRIBE HOW AND WHERE ACCIDENT OCCURRED. GIVE A COMPLETE DESCRIPTION OF CIRCUMSTANCES.	WAS INJURY DUE TO AN INTERCOLLEGIATE SPORT? <input type="checkbox"/> YES <input type="checkbox"/> NO NAME OF SPORT _____
	<input type="checkbox"/> PRACTICE <input type="checkbox"/> COMPETITION
	<input type="checkbox"/> P.E. CLASS <input type="checkbox"/> _____ CLASS
	<input type="checkbox"/> OTHER (PLEASE COMPLETE)
	DID INJURY OCCUR DURING A SCHOOL SPONSORED & SUPERVISED FIELD TRIP? <input type="checkbox"/> YES <input type="checkbox"/> NO

4 HAVE YOU SUFFERED FROM SAME OR SIMILAR CONDITION BEFORE? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, WHEN?	5 HOSPITAL NAME
PHYSICIAN WHO TREATED YOU HOSPITAL	PHYSICIAN PRESENTLY ATTENDING YOU PHONE NO.
ADDRESS	ADDRESS
CITY STATE ZIP	CITY STATE ZIP

6 HAS TREATMENT BEEN COMPLETED? YES NO IF NO, GIVE DETAILS.

7 DO YOU HAVE OTHER INSURANCE WHICH COVERS THIS CONDITION, EITHER GROUP, INDIVIDUAL, AUTOMOBILE, MEDICAL OR LIABILITY? YES NO

INSURANCE NAME & ADDRESS

CLAIMANT'S STATEMENTS

I certify I am aware that willful misrepresentation of the facts of this claim for the purpose of obtaining insurance benefits under the policy constitutes fraud and is punishable under the law, by means of a fine or imprisonment or both.

ASSIGNMENT OF BENEFITS – I hereby authorize BCS Insurance Company to pay all eligible expense benefits due me under my student insurance coverage directly to:

DOCTOR	HOSPITAL
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AUTHORIZATION TO OBTAIN INFORMATION

I AUTHORIZE any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance or reinsuring company, consumer reporting agency or employer having information available as to diagnosis, medical history, treatment and the prognosis with respect to any physical or mental condition and/or treatment of me or my minor children and any other non-medical information of me or my minor children to give such information to Myers-Stevens & Toohey & Co., Inc./BCS Insurance Company or its legal representative.

I AGREE that a photographic copy of this Authorization shall be as valid as the original, and this Authorization shall be valid for two and one half years from the date shown below.

SIGNATURE	SIGNATURE DATE	NAME OF MINOR CHILD/PATIENT	(PROPOSED) INSURED/PATIENT
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VERIFICATION OF OTHER INSURANCE

PLEASE ANSWER ALL QUESTIONS. IF FORM IS NOT COMPLETE, BENEFIT CONSIDERATION CANNOT BE MADE ON YOUR CLAIM.

1.	PATIENT'S NAME	BIRTHDATE / /	AGE	SOCIAL SECURITY NUMBER - -
HOME ADDRESS (STREET)		(CITY)	(STATE)	(ZIP)
HOME TELEPHONE NUMBER ()				
ARE YOU EMPLOYED? <input type="checkbox"/> YES <input type="checkbox"/> FULL TIME <input type="checkbox"/> PART TIME <input type="checkbox"/> NO		(If you are not employed, but are covered under your own insurance, please fill in the information below.)		
		MARTIAL STATUS <input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE	<input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED	(If married or divorced please complete Section 2)
IF EMPLOYED, PLEASE COMPLETE THE FOLLOWING:	EMPLOYER'S NAME			EMPLOYER TELEPHONE NUMBER ()
EMPLOYER'S ADDRESS (STREET)		(CITY)	(STATE)	(ZIP)
INSURANCE COMPANY NAME AND ADDRESS				
MEMBER, POLICY NUMBER				

2.	SPOUSE'S NAME			SOCIAL SECURITY NUMBER - -
IS YOUR SPOUSE EMPLOYED? <input type="checkbox"/> YES <input type="checkbox"/> NO		SPOUSE'S EMPLOYER'S NAME		TELEPHONE NUMBER ()
		(If yes, please complete the following):		()
EMPLOYER'S ADDRESS (STREET)		(CITY)	(STATE)	(ZIP)
SPOUSE'S INSURANCE COMPANY NAME AND ADDRESS				

IS STUDENT COVERED BY THIS POLICY? <input type="checkbox"/> YES <input type="checkbox"/> NO		IS THIS A HMO/PPO PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO		SPOUSE'S MEMBER, POLICY NUMBER	
3.	FATHER'S NAME			SOCIAL SECURITY NUMBER - -	
FATHER'S HOME ADDRESS				HOME TELEPHONE NUMBER ()	
IS YOUR FATHER EMPLOYED? <input type="checkbox"/> YES <input type="checkbox"/> NO		FATHER'S EMPLOYER'S NAME		TELEPHONE NUMBER ()	
		(If yes, please complete the following):		()	
FATHER'S EMPLOYER'S ADDRESS (STREET)		(CITY)	(STATE)	(ZIP)	
FATHER'S INSURANCE COMPANY NAME AND ADDRESS					

IS STUDENT COVERED BY THIS POLICY? <input type="checkbox"/> YES <input type="checkbox"/> NO		IS THIS A HMO/PPO PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO		FATHER'S MEMBER, POLICY NUMBER	
4.	MOTHER'S NAME			SOCIAL SECURITY NUMBER - -	
MOTHER'S HOME ADDRESS				HOME TELEPHONE NUMBER ()	
IS YOUR MOTHER EMPLOYED? <input type="checkbox"/> YES <input type="checkbox"/> NO		MOTHER'S EMPLOYER'S NAME		TELEPHONE NUMBER ()	
		(If yes, please complete the following):		()	
MOTHER'S EMPLOYER'S ADDRESS (STREET)		(CITY)	(STATE)	(ZIP)	
MOTHER'S INSURANCE COMPANY NAME AND ADDRESS					
IS STUDENT COVERED BY THIS POLICY? <input type="checkbox"/> YES <input type="checkbox"/> NO		IS THIS A HMO/PPO PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO		MOTHER'S MEMBER, POLICY NUMBER	

I understand that any person who knowingly and with intent to defraud any insurance company of other person files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning facts, material thereto, commits a fraudulent act, which is a crime.

SIGNATURE	DATE
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