COLLEGE CLAIM FORM

TO BE COMPLETED FOR SCHOOL SPONSORED ACTIVITIES

STATEMENT OF CLAIMANT

HAVE YOU SUFFERED FROM SAME OR SIMILAR CONDITION BEFORE?

PHYSICIAN WHO TREATED YOU

ADDRESS

CITY

STATE

ZIP

HAS TREATMENT BEEN COMPLETED?

DO YOU HAVE OTHER INSURANCE WHICH COVERS THIS CONDITION, EITHER GROUP, INDIVIDUAL, AUTOMOBILE, MEDICAL OR LIABILITY?

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

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

ITEMIZED BILLS MUST BE ATTACHED
# 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?**
   - Yes
   - No
   - [ ] Full Time
   - [ ] Part Time

   **Employer's Name**
   - **Employer's Address (Street)**
   - **City**
   - **State**
   - **Zip**
   - **Employer Telephone Number**

   **Insurance Company Name and Address**

2. **Spouse's Name**
   - **Social Security Number**
   - **Is your spouse employed?**
     - Yes
     - No
   - **Spouse's Employer's Name**
   - **Employer's Address (Street)**
   - **City**
   - **State**
   - **Zip**
   - **Employer Telephone Number**

   **Spouse's Insurance Company Name and Address**

3. **Father's Name**
   - **Social Security Number**
   - **Is your father employed?**
     - Yes
     - No
   - **Father's Employer's Name**
   - **Father's Address (Street)**
   - **City**
   - **State**
   - **Zip**
   - **Father's Telephone Number**

   **Father's Insurance Company Name and Address**

4. **Mother's Name**
   - **Social Security Number**
   - **Is your mother employed?**
     - Yes
     - No
   - **Mother's Employer's Name**
   - **Mother's Address (Street)**
   - **City**
   - **State**
   - **Zip**
   - **Mother's Telephone Number**

   **Mother's Insurance Company Name and Address**

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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**