SEE REVERSE SIDE FOR CLAIM FILING INSTRUCTIONS

1. Report school-related injuries to the school within 72 hours
2. Complete this form
3. Attach all bills
4. Mail to

Myers-Stevens & Toohey & Co., Inc.
26101 marguerite parkway
mission viejo, california 92692-3203
office (800) 827-4695 • fax (949) 348-2630

STUDENT INSURANCE CLAIM FORM

PART A SCHOOL STATEMENT (PARENT OR LEGAL GUARDIAN MAY COMPLETE PART A IF INJURY IS NOT SCHOOL RELATED)

NAME OF INSURED PERSON FIRST MI LAST | STUDENT I.D. # FROM I.D. CARD

NAME OF SCHOOL | NAME OF SCHOOL DISTRICT | AGE | GRADE | ☐ FEMALE ☐ MALE | DATE OF BIRTH MO / DAY / YR

ADDRESS OF SCHOOL | CITY | STATE | ZIP CODE

DATE OF INJURY/SICKNESS MO / DAY / YR | TIME OF INJURY : A.M. / P.M. (CIRCLE ONE) | INJURY OCCURRED: PLEASE ✓ ONE ☐ Interscholastic Practice ☐ Interscholastic Game ☐ P.E. ☐ Classroom ☐ Travel ☐ At Home ☐ Field Trip ☐ Other______ | TYPE OF SPORT

DETAILS OF SICKNESS OR HOW THE INJURY OCCURRED. PLEASE BE SPECIFIC | WAS STUDENT PARTICIPATING IN SPORT NOT SCHOOL-RELATED? (IF YES, LIST NAME AND PHONE NO. OF GROUP) ☐ YES ☐ NO

WHAT PART OF THE BODY WAS INJURED? | HAS THE STUDENT SUFFERED FROM SAME OR SIMILAR CONDITION BEFORE? ☐ YES ☐ NO IF YES, WHEN?

NAME AND TITLE OF SCHOOL SUPERVISOR | WAS HE/SHE A WITNESS TO THE ACCIDENT? ☐ YES ☐ NO | DATE SCHOOL WAS NOTIFIED OF ACCIDENT

NAME OF SCHOOL OFFICIAL | SIGNATURE OF SCHOOL OFFICIAL X | DATE SIGNED | SCHOOL TELEPHONE NO. ( )

PART B PARENT OR LEGAL GUARDIAN STATEMENT

(PLEASE PRINT OR TYPE CLEARLY)

IS THIS STUDENT COVERED BY OTHER HEALTH AND/OR ACCIDENT INSURANCE PLANS?
☐ NO ☐ YES IF YES, NAME OF ORGINIZATION (S)

NAME OF FATHER OR LEGAL MALE GUARDIAN | DATE OF BIRTH OF FATHER OR LEGAL MALE GUARDIAN | HOME TELEPHONE NO. ( )

ADDRESS | CITY | STATE | ZIP CODE

NAME OF EMPLOYER ☐ Self Employed ☐ Part Time ☐ Unemployed | WORK TELEPHONE AND EXTENSION NO. ( )

ADDRESS OF EMPLOYER | CITY | STATE | ZIP CODE

NAME OF OTHER HEALTH AND/OR ACCIDENT INSURANCE COMPANY THROUGH FATHER OR LEGAL MALE GUARDIAN | POLICY NUMBER | TELEPHONE NO. ( )

MAILING ADDRESS OF INSURANCE COMPANY | CITY | STATE | ZIP CODE

NAME, ADDRESS AND PHONE NO. OF STUDENT'S FAMILY PHYSICIAN | CITY | STATE | ZIP CODE | TELEPHONE NO. ( )

NAME OF MOTHER OR LEGAL FEMALE GUARDIAN | DATE OF BIRTH OF MOTHER OR LEGAL FEMALE GUARDIAN | HOME TELEPHONE NO. ( )

ADDRESS | CITY | STATE | ZIP CODE

NAME OF EMPLOYER ☐ Self Employed ☐ Part Time ☐ Unemployed | WORK TELEPHONE AND EXTENSION NO. ( )

ADDRESS OF EMPLOYER | CITY | STATE | ZIP CODE

NAME OF OTHER HEALTH AND/OR ACCIDENT INSURANCE COMPANY OF MOTHER OR LEGAL FEMALE GUARDIAN | POLICY NUMBER | TELEPHONE NO. ( )

MAILING ADDRESS OF INSURANCE COMPANY | CITY | STATE | ZIP CODE

I understand that any person who knowingly and with intent to defraud any insurance company or 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, and may subject such person to fines and/or imprisonment.
I hereby authorize any school authority, trust fund, employer, insurance company or person who has attended or examined the claimant to disclose to Myers-Stevens & Toohey & Co., Inc., when requested to do so, any information regarding any injury, illness, policy coverage, medical history, consultation, prescription or treatment, and copies of all hospital or medical records and itemized bills, and to pay benefits based upon this information. A photostatic copy of this authorization shall be considered as valid and effective as the original.

PARENT OR LEGAL GUARDIAN SIGNATURE X

RELATIONSHIP TO STUDENT | DATE

AUTHORIZATION TO PAY BENEFITS TO PROVIDER. I authorize payment of Medical payments to Physician or Supplier for Services on the attached.

SIGNATURE OF PARENT OR LEGAL GUARDIAN________________ DATE__________

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