

STUDENT SECURITY PLAN CLAIM REPORT

Complete this form **IN FULL**. If any applicable questions are not answered in full, you will be required to complete an additional report. The attached authorization must be signed and dated. The properly completed claim form and all applicable bills must be submitted within 90 days of the date of loss to qualify your claim for payment. Checks for benefits will automatically be sent to your hospital, doctor, or other supplier of medical services unless you submit a signed statement requesting that payment be made to someone else.

**MAIL TO: POLICY BENEFITS
BOX 8025
STEVENS POINT, WISCONSIN 54481
1-800-426-7234 Toll-Free**

SEVERAL STATES REQUIRE THE FOLLOWING STATEMENT TO APPEAR ON THIS FORM:

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO FRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES A STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS INFORMATION CONCERNING ANY MATERIAL FACT FOR THE PURPOSE OF MISLEADING, COULD BE GUILTY OF INSURANCE FRAUD WHICH MAY BE A CRIME. THIS DOES NOT APPLY TO VIRGINIA RESIDENTS.

College or University: _____ State: _____

Student's Name: _____
(LAST NAME) (FIRST NAME) (INITIAL)

Student's Mailing Address (mail will be sent to this address): _____
(STREET) (CITY) (STATE) (ZIP)

Email Address _____ May we contact you via Email? Yes No

Date of Birth: _____ Marital Status: Single Married

If Married, Spouse's Name: _____

Spouse's Employment Status: Does Not Work Works Part-time Works Full-time

Claim if for: Above Student Dependent: _____
(NAME)

Dependent's Date of Birth: _____ Relationship to Student: _____

MUST COMPLETE FOR ACCIDENT CLAIM	DATE OF ACCIDENT: _____ DESCRIBE NATURE OF INJURY: _____ HOW DID ACCIDENT HAPPEN? _____ WHERE DID ACCIDENT HAPPEN? <input type="checkbox"/> HOME <input type="checkbox"/> WORK <input type="checkbox"/> ON CAMPUS - SPECIFY WHERE: _____ <input type="checkbox"/> WHILE TRAVELING <input type="checkbox"/> OTHER - SPECIFY _____ _____ IF SPORTS INJURY - NAME OF SPORT: _____ IF COLLEGE SPORT CHECK APPROPRIATE BOX: <input type="checkbox"/> INTRAMURAL <input type="checkbox"/> INTERCOLLEGIATE IF NON-COLLEGE SPORT: <input type="checkbox"/> SEMI-PROFESSIONAL <input type="checkbox"/> OTHER (PLEASE SPECIFY): _____
MUST COMPLETE FOR SICKNESS CLAIM	NATURE OF ILLNESS: _____ DATE OF FIRST SYMPTOMS: _____ DATE OF FIRST TREATMENT: _____ NAME OF PHYSICIAN FIRST CONSULTED: _____ PHYSICIAN'S ADDRESS: _____
MUST COMPLETE IF TREATED IN STUDENT HEALTH SERVICE	DATES OF TREATMENT: _____ REFERRED TO: _____ SIGNATURE OF STUDENT HEALTH SERVICES OFFICIAL: _____
STATEMENT OF OTHER APPLICABLE INSURANCE - MUST COMPLETE THIS SECTION	DO YOU HAVE COVERAGE UNDER ANOTHER INSURANCE PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO NAME OF INSURANCE COMPANY: _____ INSURANCE IS: <input type="checkbox"/> PERSONAL <input type="checkbox"/> EMPLOYER'S GROUP <input type="checkbox"/> PARENT'S GROUP <input type="checkbox"/> OTHER (DESCRIBE) _____ PARENT'S NAME: _____ PARENT'S ADDRESS: _____ PARENT'S EMPLOYER: _____ EMPLOYER'S ADDRESS: _____
STUDENT'S VERIFICATION OF INSURANCE	I VERIFY THAT THE ABOVE STATEMENT ON OTHER INSURANCE IS ACCURATE AND COMPLETE. I UNDERSTAND THAT THE INTENTIONAL FURNISHING OF INCORRECT INFORMATION VIA THE U.S. MAIL MAY BE FRAUDULENT AND VIOLATE FEDERAL LAWS. STUDENT'S SIGNATURE: _____ DATE: _____

AUTHORIZATION

I, _____, authorize all physicians and other medical professionals, pharmacies, hospitals and other medical care institutions, and insurers, medical or hospital service and prepaid health plans, employers and group policyholders, contract holders, or benefit plan administrators:

i. to disclose the following health information:

copies of all medical records and/or medical information indicated on the attached request, including information related to mental illness, AIDS, drug or alcohol abuse history, and treatment.

ii. to the following person(s) or entity:

Sentry Life Insurance Company

iii. for the purpose of processing a claim for benefits under an insurance contract.
[may state "at my request"]

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my eligibility to obtain treatment, payment, enrollment, or my eligibility for benefits. This statement does not apply to disability, life, property/casualty (including workers' compensation) policies even though they involve the payment of medical expenses. I have received two copies of the authorization and understand I may retain a copy of this authorization for my records. **I agree that a photocopy of this authorization is as valid as the original.**

I understand that I may revoke this authorization at any time by sending a written request to Sentry Life Insurance Company, P.O. Box 8025, Stevens Point, WI 54481. I am aware that a revocation will not have any affect on any use or disclosure of protected health information by Sentry before it received the revocation.

This authorization expires in 6 months from the date signed below.

I understand that if protected health information about me is disclosed to a person or organization that is not required to comply with federal privacy regulations, the information may be redisclosed and no longer protected by the federal privacy regulations.

Signature of Person Authorizing

Date

Name of Personal Representative (if applicable): _____

Relationship of Personal Representative: _____