NAME OF SCHOOL: _____ HEALTH CENTER REFERRAL: No ❑ Yes ❑ **IF YES, REFERRAL MUST BE ATTACHED**

POLICY NUMBER: _____ REFERRAL GIVEN BY: _____ DATE: _____

MAIL TO: QBE Insurance Corporation, Personal Insurance Administrators, Inc., P.O. Box 6040, Agoura Hills, CA 91376-6040, 1-800-468-4343

Name of Student _____ Student ID Number_____ S.S. Number _____ Date of Birth_____

Current Home Address _____
Number and Street City State Zip Code Phone Number

Name of Insured Dependent _____ Date of Birth _____
if applicable

Current Home Address _____
Number and Street City State Zip Code

CLAIM WILL BE RETURNED IF THIS SECTION IS NOT FULLY COMPLETED

1. Date of injury or beginning of sickness _____ When was physician first consulted? _____
2. Nature of injury or sickness _____
3. If injury, describe how and where accident occurred _____
4. Did injury occur during practice or play of sports? No ❑ Yes ❑
   If yes, please check one of the following: ❑ Intramural/Club Name of Sport _____
   ❑ Intercollegiate Signature of Athletic Trainer _____
   ❑ Other _____
5. Have you suffered same or similar condition before? No ❑ Yes ❑
   If yes, and you were previously treated for it, dates treated: _____
   Name and address of physician who treated you: _____
6. If hospitalized at that time, date confined to hospital: _____
   Name and address of hospital: _____
7. Was the injury the result of a motor vehicle accident? No ❑ Yes ❑

Do you have other insurance which covers your condition (group, individual, automobile, medical or liability)? No ❑ Yes ❑

If yes, who is the Holder of Policy: Self ❑ Parent ❑ Spouse ❑ Give name of company _____

If covered under Parent's/Spouse's Insurance or if privately insured, please include the following information:

Policy No._____ Group No. _____ Phone No. of Insurance Co._____

Parent's/Spouse's Name (Holder of Policy) _____ S.S. No. _____

Employer's Name and Address _____

Have you been insured under another health insurance plan any time during the past 12-month period? No ❑ Yes ❑

If yes, give name of company and attach a copy of your Certificate of Prior Coverage (*unless previously submitted*) _____

Address:_____ Phone Number: _____

Policy Number:_____ Effective Date of Coverage: _____ Date Coverage Terminated: _____

ASSIGNMENT OF BENEFITS

CLAIMANT (OR PARENT, IF MINOR) MUST COMPLETE IN FULL INDICATING TO WHOM PAYMENT IS TO BE MADE. (PLEASE PRINT.)

Dr.: _____ Hosp: _____ Other: _____

Address / City State — Address / City State — Address / City State

IMPORTANT: THIS FORM MUST BE COMPLETED AND RETURNED TO THE COMPANY WITHIN 90 DAYS FROM THE DATE OF TREATMENT ACCOMPANIED BY ALL BILLS INCURRED TO THAT DATE. PLEASE ATTACH ITEMIZED BILLS.

For your protection, State Law requires that the following appear on this form: "Any Person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison."

AUTHORIZATION: I hereby authorize QBE Insurance Corporation, or its representative, to inspect or secure copies of case history records, laboratory reports, diagnosis, prognosis, x-rays, and any other data covering this and/or previous confinements and/or disabilities. A photostatic copy of this authorization shall be deemed as effective and valid as the original.

I hereby authorize QBE Insurance Corporation to pay bills in connection with this claim directly to the Doctor, Hospital or Other Payee indicated above. I understand that I or my authorized representative is entitled to receive a copy of this authorization upon request.

SIGNATURE OF STUDENT _____ **DATE** _____