

Claim Serial Number (for office use only)



First Agency
5071 West H Avenue
Kalamazoo, MI 49009-8501

ACCIDENT CLAIM FORM

PARENT/GUARDIAN TO COMPLETE

ALL INFORMATION MUST BE COMPLETE OR CLAIM CANNOT BE PROCESSED

Student's Full Name _____

Exact Date of Accident _____

Student's Social Security Number _____

Student's Date of Birth _____

Please note that the Injured Person's Social Security Number MUST be provided as required by the Center for Medicare Services pursuant to Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007.

FATHER	MOTHER
Father's Full Name _____	Mother's Full Name _____
Home Address _____	Home Address _____
City _____ State _____ Zip _____	City _____ State _____ Zip _____
Home Phone _____	Home Phone _____
Employer Name _____	Employer Name _____
Employer Address _____	Employer Address _____
City _____ State _____ Zip _____	City _____ State _____ Zip _____
Self Employed? <input type="checkbox"/> YES <input type="checkbox"/> NO	Self Employed? <input type="checkbox"/> YES <input type="checkbox"/> NO
PLEASE COMPLETE THE FOLLOWING SECTION EVEN IF NO BENEFITS ARE PROVIDED:	PLEASE COMPLETE THE FOLLOWING SECTION EVEN IF NO BENEFITS ARE PROVIDED:
Do you have insurance? <input type="checkbox"/> YES <input type="checkbox"/> NO Is this student covered? <input type="checkbox"/> YES <input type="checkbox"/> NO	Do you have insurance? <input type="checkbox"/> YES <input type="checkbox"/> NO Is this student covered? <input type="checkbox"/> YES <input type="checkbox"/> NO
Name of Insurance Plan _____	Name of Insurance Plan _____
Social Security Number _____	Social Security Number _____
Phone Number _____ Group Number _____	Phone Number _____ Group Number _____
If you are employed, but your dependent is not covered under your employer's plan, a letter to this effect from your employer is required.	If you are employed, but your dependent is not covered under your employer's plan, a letter to this effect from your employer is required.

AUTHORIZATION - To Permit Use and Disclosure of Health Information



First Agency
5071 West H Avenue
Kalamazoo, MI 49009-8501

This Authorization was prepared by First Agency for purposes of obtaining information necessary to process a claim for benefits.

Upon presentation of the original or a photocopy of this signed Authorization, I authorize, without restriction (except psychotherapy notes), any licensed physician, medical professional, hospital or other medical-care institution, insurance support organization, pharmacy, governmental agency, insurance company, group policyholder, employer or benefit plan administrator to provide First Agency or an agent, attorney, consumer reporting agency or independent administrator, acting on its behalf, all information concerning advice, care or treatment provided the patient, employee or deceased named below, including all information relating to, mental illness, use of drugs or use of alcohol. This Authorization also includes information provided to our health division for underwriting or claim servicing and information provided to any affiliated insurance company on previous applications. If this Authorization is for someone other than myself, that individual has given me the authority to act on his/her behalf as explained below.

I understand that I have the right to revoke this Authorization, in writing, at any time by sending written notification to my agent or to us at the above address. I understand that a revocation will not be effective to the extent we have relied on the use or disclosure of the protected health information or if my Authorization was obtained as a condition to determine my eligibility for benefits. Revocation requests must be sent in writing to the attention of the Claims Supervisor.

I understand that First Agency may condition payment of a claim upon my signing this authorization, if the disclosure of information is necessary to determine the level or validity of the claim payment. I also understand, once information is disclosed to us pursuant to this Authorization, the information will remain protected by First Agency, Inc. in accordance with federal or state law.

I understand that I or my authorized representative is entitled to receive a copy of this authorization upon request.

This Authorization is valid from the date signed for the duration of the claim.

Name of Authorized Representative, or Next of Kin _____

Name of Claimant _____

Signature of Authorized Representative or Next of Kin _____ Date _____

Signature of Claimant (If claimant is 18 or older) _____ Date _____

Relationship of Authorized Representative or Next of Kin to Claimant _____

SCHOOL/ADMINISTRATOR/OFFICIAL/POLICYHOLDER TO COMPLETE

School Student Attends _____ in _____ School District _____

Student's Full Name (Last, First, MI): _____ Sex: Male Female Grade: _____

Student's Home Address: _____

Date of Accident: _____ Time of Accident: _____ AM PM

Detailed Description of Accident: How did it occur? (or attach accident report completed by the school representative who witnessed the accident) _____

Where did it occur? _____

Part of body injured: _____ Right Left

Activity: _____ Interscholastic Intramural Club Other (describe) _____

Name of school authority supervising activity: _____

Was supervisor a witness to the accident? Yes No If No, date reported to school: _____

Signature of School Official: _____ Date: _____ Title of School Official: _____

BERKLEY ACCIDENT AND HEALTH FRAUD LANGUAGE

FOR RESIDENTS OF ALL STATES OTHER THAN THOSE LISTED BELOW:

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

ARIZONA: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

ALASKA and KENTUCKY: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false, incomplete or misleading information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and may be prosecuted under state law.

CALIFORNIA: For your protection California law requires the following to 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.

COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

FLORIDA: WARNING :Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

GEORGIA: Any natural person who knowingly or willfully

- 1) Makes or aids in the making of any false or fraudulent statement or representation of any material fact or thing:
 - a) In any written statement;
 - b) In the filing of a claim; or
 - c) In the receiving of money for an application for a policy of insurance for the purpose of procuring or attempting to procure the payment of any false or fraudulent claim or other benefit by an insurer;
- 2) Receives money for the purpose of purchasing insurance and converts such money to such persons own benefit;
- 3) Issues fake or counterfeit insurance policies, certificates of insurance, insurance identification cards, or insurance binders; or
- 4) Makes any false or fraudulent representation as to the death or disability of a policy or certificate holder in any written statement for the purpose of fraudulently obtaining money or benefit from an insurer commits the crime of insurance fraud.

NEW HAMPSHIRE: Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

NEW JERSEY: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NEW MEXICO and PENNSYLVANIA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

VIRGINIA: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

NEW YORK: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.