MAIL CLAIMS TO: Coordinated Benefit Plans, P.O. Box 20874, Tampa, FL 33623

IF YOU NEED ASSISTANCE: Toll Free: 1-877-902-9926 / Email: TEAM2@CBPINSURE.COM

CLAIMANT'S NOTICE OF CLAIM

PART A Claim Form

1. FULL NAME (Claimant)	**2. DATE OF BIRTH**	**3. TELEPHONE NUMBER** ( )
4. STREET ADDRESS	**5. CITY, STATE, ZIP**	
6. NAME OF INSTITUTION Chowan University	**POLICY NUMBER** CL 001010	
7. DATE OF INJURY OR FIRST TREATMENT OF SICKNESS / /	**8. IF AN ACCIDENT, WHAT WAS THE TIME OF INJURY** AM / PM	
9. IF HOSPITALIZED, HOSPITAL NAME HOSPITAL TEL. NO. ( )	**10. STREET ADDRESS**	
11. CITY, STATE, ZIP	**12. HOSPITAL CONFINEMENT DATES** From: | To:	
13. If an Accident, explain HOW the accident and injury occurred. NOTE: If your organization uses an Accident Report Form, attach a copy of the Report.		
14. If an Accident, describe the nature of injury.		
15. If an Accident, at what location did the injury occur?		

NOTICE

This claim form MUST be received by the Insurance Company within 90 days of the date of injury or first treatment for sickness. Benefits will be paid for eligible expenses. Expenses must be incurred within 52 weeks after the date of the accident or first treatment for sickness.

CLAIM PROCEDURE

1. If the Claimant (Insured) is under age 18 or is otherwise a dependent, his/her Parent or Guardian MUST **complete, date** and **sign** PART B of this claim form.
2. After PARTS A and B of this claim form have been completed in full, mail the entire claim form to the address shown above **within 90 days** of the date of injury or first treatment for sickness.
3. In addition, send all medical bills to the address shown above.

PART B – This PART MUST be completed, dated and signed by the Claimant – or if the Claimant is under age 18 or otherwise dependent – by his/her Parent or Guardian.

PRINT HERE – NAME OF PERSON COMPLETING FORM: Check one: Claimant Δ Parent Δ Guardian Δ

Give the following information about the Claimant:

1. Date of Birth Mo. Day Year / /	2. Male Δ Female Δ	3. Social Security No. / /	4. Area Code/Telephone No. ( )

5. Employer (Name) ADDRESS: (Street) (City) (State) (Zip)
(if applicable)

Area Code/Employer Telephone No.
( )

6. Is the Claimant covered under any other health and/or accident insurance plans? Yes Δ No Δ
If YES, give the following information:

Name of Other Insurance Company(s) Address Policy Number(s)

Policyholder Name and Address Social Security No. / /

Relationship to Claimant: Area Code/Telephone No. ( )

7. If the Claimant is married, give the following information: Name of Spouse Social Security No. / /

Area Code/Telephone No. ( )

I authorize any insurer, hospital, physician or other person who has attended or examined the Insured Person to disclose, when requested to do so, all information with respect to any injury, sickness, policy coverages, medical history, consultation, prescription or treatment, and copies of all hospital or medical records and itemized bills. A photostatic copy of this authorization shall be considered as effective and valid as the original. The above information is true and complete to the best of my knowledge and belief.

I also Authorize Aegis Group of Pennsylvania or its representatives to pay all bills in connection with this claim directly to the doctor, hospital or any other persons rendering service, and such payment shall release Aegis Group of Pennsylvania from liability as to amounts so paid.

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 (in FL, a felony in the third degree), and in the state of New York, 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.

⌋ Claimant

X _____ Check one: Δ Parent Date: _____
Signature (in writing) of Responsible Party Print Name Δ Guardian