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# Student Accident Claim Form

Please complete and submit to A-G Administrators with itemized medical bills and primary insurance explanation of benefits. For questions, please contact A-G Administrators.

College/University \_\_\_\_\_

Student's Name \_\_\_\_\_  
FIRST NAME MIDDLE INITIAL LAST NAME

Date of Birth \_\_\_\_\_ Sex:  M  F Cell Phone \_\_\_\_\_

Email Address \_\_\_\_\_

School Address \_\_\_\_\_  
STREET CITY STATE ZIP

Home Address \_\_\_\_\_  
STREET CITY STATE ZIP

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**ACCIDENT INFORMATION**

Place of Accident \_\_\_\_\_ Accident Date \_\_\_\_\_

Circumstance:  Game  Practice  Conditioning  Other Type of Injury:  Club Sport  Intramural  
 Intercollegiate  Non-athletic

Body Part Injured \_\_\_\_\_ Sport if Athletic \_\_\_\_\_

Nature of Injury — Details of What Happened \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

.....  
**INSURANCE INFORMATION**

Does the claimant have primary insurance?  Yes  No *(Attach separate sheet if necessary.)*

Insurance Company Name & Address \_\_\_\_\_

Policy Number \_\_\_\_\_ ID# \_\_\_\_\_

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**AUTHORIZATION**

**AFFIDAVIT:** I verify that the 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 as well as state laws. I agree that if it is determined at a later date that there are other insurance benefits collectible on this claim I will reimburse A-G Administrators to the extent for which A-G Administrators would not have been liable.

**AUTHORIZATION TO RELEASE INFORMATION:** I authorize any Health Care Provider, Doctor, Medical Professional, Medical Facility, Insurance Company, Person or Organization to release any information regarding medical, dental, mental, alcohol or drug abuse history, treatment or benefits payable, including disability or employment related information concerning the patient, to A-G Administrators and its designees.

**PAYMENT AUTHORIZATION:** I authorize all current and future medical benefits, for services rendered and billed as a result of this claim, to be made payable to the physicians and providers indicated on the invoices.

\_\_\_\_\_  
**STUDENT SIGNATURE** *(Parent or guardian, if participant is a minor)* Date

\_\_\_\_\_  
**SCHOOL OFFICIAL SIGNATURE** Title Date