

STUDENT ACCIDENT CLAIM FORM

HOW TO FILE YOUR CLAIM



- 1. Complete this form within 90 days.
- 2. Attach itemized bills.
- 3. Mail to: **Health Special Risk, Inc.**
HSR Plaza II
4100 Medical Parkway
Carrollton, TX 75007
Phone Number: 888-765-7223



MARKEL INSURANCE COMPANY

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines and denial of insurance benefits.

PART 1: SCHOOL

School and District Name: _____ Policy No.: _____
Address: _____ (Street) _____ (City) _____ (State) _____ (Zip)
Claimant's Name: _____ Date of Birth: _____ Male or Female
Date of Injury: _____ Time: _____ AM PM Grade: _____
Where did injury occur? _____
How did injury occur? _____
Nature of Injury: _____
If athletics, please name the sport: _____ What type: Intramural Interscholastic Other: _____
On date of injury, what time did school start for this student? _____ What time was student dismissed from school? _____
At the time of injury, was the claimant involved in any activity under the jurisdiction of the Policyholder? Yes No
Under whose supervision? _____ Was he/she a witness? _____
Signature: x _____ Title _____ Date _____
(Must be signed by a school official if the accident was school related)

PART 2: Claimant's Section
Provide both *claimant* and *parent* information

Claimant Information
Claimant's Social Security Number _____ Phone Number (____) _____
Claimant's Street Address _____ City _____ State _____ Zip _____

Parent Information
Claimant's Father's Name _____ Social Security Number _____
Father's Employer _____
Street Address _____ City _____ State _____ Zip _____
Claimant's Mother's Name _____ Social Security Number _____
Mother's Employer _____
Street Address _____ City _____ State _____ Zip _____

Please list ALL OTHER insurance policies:

Name of Other Insurer: _____	No Other Insurance
Address: _____	Group _____ Policy No. _____
Phone # _____	<input type="checkbox"/> Individual _____ Policy No. _____
Name of Other Insurer: _____	<input type="checkbox"/> Other _____ Policy No. _____
Address: _____	<input type="checkbox"/>
Phone # _____	<input type="checkbox"/>

AUTHORIZATION FOR RELEASE OF INFORMATION: I AUTHORIZE any physician, medical care provider, hospital, clinic, medical care facility, insurance company, government-sponsored health plan, or employer having information available as to diagnosis, treatment and prognosis with respect to any illness, injury, physical or mental condition, and/or treatment for me or my minor children now or in the past, to give to Markel Insurance Company (MIC) or its legal representative, any and all such information.

I UNDERSTAND the information obtained by the use of the Authorization will be used by MIC to determine eligibility for insurance and eligibility for benefits under any existing policy. Any information obtained will not be released by MIC to any person or organization EXCEPT as necessary in connection with the processing of this application, claim, or as may be otherwise lawfully required or as I may further authorize. I KNOW that I may request to receive a copy of this Authorization.

I AGREE that a photographic copy of this Authorization shall be as valid as the original. I also AGREE this Authorization shall be valid for a period of two years from the date shown below. I may revoke this authorization at any time by written request to MIC.

I CERTIFY that the information given by me in support of this claim is true and correct.

PAYMENT WILL BE MADE TO THE PROVIDERS OF SERVICE (HOSPITAL, PHYSICIAN AND OTHERS), UNLESS A PAID RECEIPT OR STATEMENT ACCOMPANIES THE BILL AT THE TIME THE CLAIM IS SUBMITTED.

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 Markel Insurance Company to the extent for which Markel Insurance Company would not have been liable.

Claimant, Parent or Authorized Representative's Signature: _____ **Date** _____
 If Authorized Representative, Relationship to Patient or Legal Designation: _____

ITEMIZED BILLS FOR MEDICAL EXPENSES MUST BE ATTACHED

IF DENTISTRY, ANSWER ALL QUESTIONS BELOW, IN ADDITION TO THOSE ABOVE.

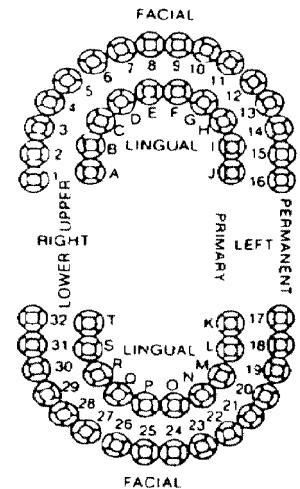
1. State exactly which teeth were involved in the accident and indicate them on the chart:

2. Describe exact nature of injury:

3. Describe condition of injured teeth prior to accident:

Whole, sound and natural Filled Capped Artificial

4. _____



SIGNED: _____ DEGREE: _____ DATE: _____

PRINT NAME: _____

I.D. OR S.S. NO. _____ (THIS MUST BE INCLUDED) PHONE NO. (____) _____

ADDRESS _____
 (STREET) (CITY) (STATE) (ZIP)

IMPORTANT: This form must be completed and returned WITHIN 90 DAYS from the date of treatment, accompanied by all bills incurred to that date.

