PROOF OF CLAIM

This form should be completed and submitted to the Company within 90 days from date of injury.

Mail completed form to:
STUDENT ASSURANCE SERVICES, INC.
P.O. BOX 196
STILLWATER, MINNESOTA 55082

NOTICE: *Anyone who knowingly misrepresents or falsifies essential information requested by this form may upon conviction be subject to fine or imprisonment.*

CLAIM PROCEDURE:

1. An employee of the Policyholder should complete PART A.
2. If the Insured is age 18 or older, he/she should complete PART B. If the Insured is under age 18, his/her parents or guardian should complete PART C.
3. If dental charges — have statement completed on back.
4. See ***REVERSE SIDE*** for important claim procedures.

PLEASE PRINT OR TYPE ALL INFORMATION PROVIDED

TO BE COMPLETED BY THE POLICYHOLDER

PART A: NOTICE OF INJURY

1. Name of Policyholder PURSUIT SOCCER CLUB, INC.
   Policyholder's Address 4008 Louetta Road #191, Spring (City) TX (State) 77388-4005 (Zip)
2. Name of Insured ______ Social Security # ___-__-____
3. Age ______ Date of Injury ______ ☐AM ☐PM
4. Under whose supervision? ______ Was he/she a witness? ______
5. The accident was incurred while the Insured was participating in: ______
6. Part of the body injured ______ ☐R ☐L
7. Describe in detail how and where the injury occurred ______

Reported by ______
(Signature of Policyholder Official) (Title) (Date)

PART B

PART B: (To be completed by the Insured if over age 18)

1. Insured's Name ______ Phone ______
   Address ______
   (Street) (City) (State) (Zip)
2. Are you employed? If so, name of employer ______
3. List your family or group insurance policies:
   Name of Insurance Company ______ Policy No. ______
   Address ______
   (Street) (City) (State) (Zip)

PART C

PART C: (To be completed by the Insured Student's Parents or Guardian if the Insured is a minor under age 18)

1. Parent's/Guardian's Name ______ Home Phone ______
   Address ______
   (Street) (City) (State) (Zip)
2. Father's Occupation ______ Employer ______
   Mother's Occupation ______ Employer ______
3. List your family or group insurance policies:
   Name of Insurance Company ______ Policy No. ______
   Address ______
   (Street) (City) (State) (Zip)

I hereby authorize any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance company, or other organization, institution, or person that has any records or knowledge of the claimant's physical or mental health, to give the information to STUDENT ASSURANCE SERVICES, INC. To facilitate rapid submission of such information, I authorize all said sources to give such records or knowledge to any agency employed by the insurance company to collect and transmit such information. A photocopy of this authorization shall be as valid as the original. This authorization expires one year from the date signed.

______ (Date) ______ (Print Name of Insured/Patient) ______ (Insured Signature or Parent/Guardian if Insured is Under 18 years of age)

STEPS TO FOLLOW WHEN FILING A CLAIM:

1. A Policyholder official **must** complete Part A for all Policyholder related accidents. If the Insured is age 18 or older, he/she should complete PART B. If the Insured is under age 18, his or her parents or guardian should complete PART C. **Do NOT leave this Claim Form with the physician or hospital. Complete and submit directly to the Claims Office at the address indicated below.**

2. Send copies of **itemized bills**. These are the original billings you receive, not monthly statements. **All bills must include the provider's Tax ID Number.**

3. Submit copies of all bills to your family and/or group insurance, even if you have a large deductible. This plan is supplemental to all other valid coverage. You must file a claim with your other insurance first. This plan does not cover penalties imposed for failure to use providers preferred or designated by your primary coverage. After you have received payment or copies of "Explanation of Benefits" (EOB) from your family insurance company or insurance administrator (Blue Cross, Group Health, Prudential Insurance, etc.), **send our claim form, copies of itemized bills and your other insurance E.O.B.'s to:**

STUDENT ASSURANCE SERVICES, INC.
P.O. BOX 196
STILLWATER, MN 55082-0196

NO CLAIM CAN BE PROCESSED UNTIL ALL OF THE ABOVE DOCUMENTS ARE PROVIDED.

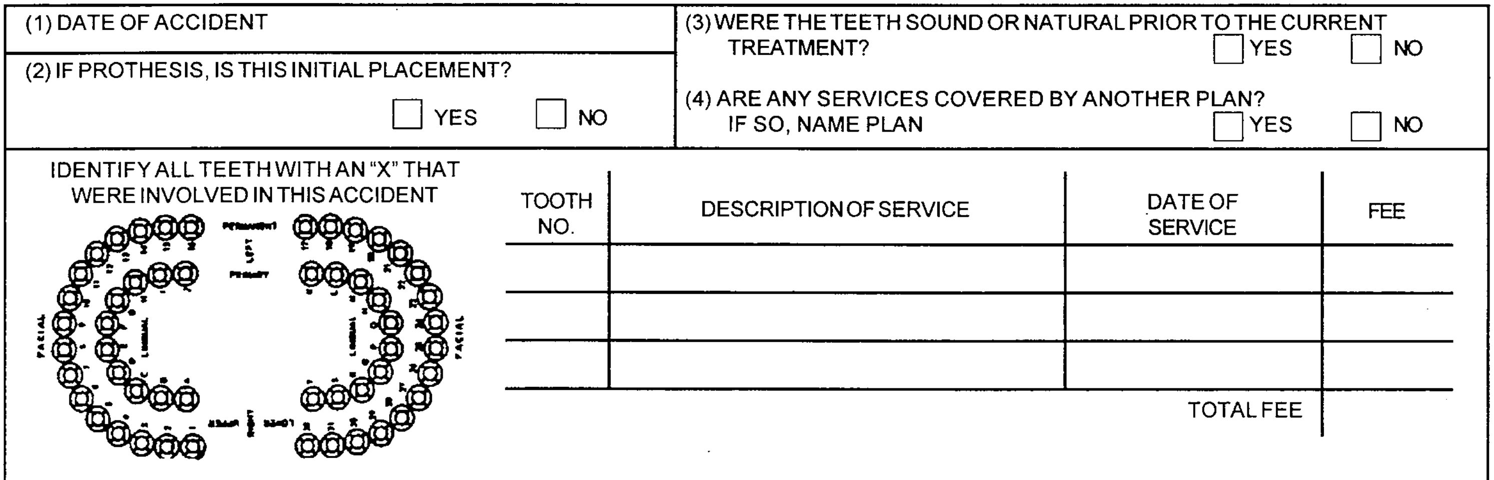
4. Insureds must be treated by a licensed medical physician within 60 days from the date of the injury.

5. Proof of claim should be submitted within 90 days from the date of injury, or a reasonable time thereafter not to exceed one year.

6. The policy allows benefits for expenses actually incurred within one year from the date of injury.

THE MASTER POLICY IS ISSUED TO THE POLICYHOLDER. THE POLICY CAN BE VIEWED AT THE POLICYHOLDER'S OFFICE.

ATTENDING DENTIST'S STATEMENT



(1) DATE OF ACCIDENT

(2) IF PROTHESIS, IS THIS INITIAL PLACEMENT? ☐ YES ☐ NO

(3) WERE THE TEETH SOUND OR NATURAL PRIOR TO THE CURRENT TREATMENT? ☐ YES ☐ NO

(4) ARE ANY SERVICES COVERED BY ANOTHER PLAN? IF SO, NAME PLAN ☐ YES ☐ NO

IDENTIFY ALL TEETH WITH AN "X" THAT WERE INVOLVED IN THIS ACCIDENT

TOOTH NO.	DESCRIPTION OF SERVICE	DATE OF SERVICE	FEE
		TOTAL FEE	

X

DENTIST'S NAME

SIGNATURE DEGREE

STREET ADDRESS

DATE

CITY STATE ZIP

( )
TELEPHONE

Federal ID Number — No benefits can be paid without your ID number.