When completed, return this form to:

Valparaiso University
Student Health Center
1406 LaPorte Ave.
Valparaiso IN 46383
Phone: 219-464-5060

or

Plan Administrator
Special Risk Claims
Commercial Travelers Mutual Ins. Co.
70 Genesee Street
Utica, NY 13502 Phone: 800-756-3702

To locate the nearest Network Provider, contact:

800-513-7177
www.novanetppo.com

Underwriting Company: Companion Life Insurance Company, Columbia, SC

NOTIFICATION OF INJURY OR SICKNESS - STUDENT INSURANCE MEDICAL CLAIM FORM

(Please Print Clearly)

COLLEGE/UNIVERSITY: Valparaiso University POLICY NO: _____

Student Name: _____ ☐ Male ☐ Female

Student ID No.: _____ Date of Birth: Month:_____ Day: _____ Year: _____

Current Address: _____
(Street) (City) (State) (Zip Code)

Phone: _____ E-mail: _____

If Claim is for Dependent:
Name of Dependent: _____
☐ Male ☐ Female Date of Birth: _____ Relationship:_____

1. Date of Injury (or) onset of Sickness: _____ When was physician First Consulted? _____

2. Nature of Injury (or) Illness: _____

3. If Injury, (a) how and where did accident occur? _____

(b) Were you practicing or playing any intercollegiate (between rival colleges) sport at the time of the Accident? ☐ Yes ☐ No

If "Yes", name the Sport: _____ Approved by: _____
(Athletic Trainer or Director)

4. Were you treated and/or referred by the Student Health Center? ☐ Yes ☐ No If "Yes", date: _____

Referred by: _____
(College Health Care Provider)

5. Have you suffered same or similar condition in the past? ☐ Yes ☐ No

If "Yes", and if you were treated for it, please give name and address of the physician who treated you.

Name: _____Address: _____ Date Treated: _____

6. Was injury the result of a motor vehicle accident? ☐ Yes ☐ No

7. Was the injury or sickness a result of your employment? ☐ Yes ☐ No

8.Do you, your spouse or your parents have any other insurance or medical plan that covers this condition, either Group, Individual, Automobile, Medical or Liability? ☐ Yes ☐ No

I hereby authorize any physician, hospital, company, employer or organization to release any information regarding the medical history, treatment or benefits payable for this claim to the Insurance Company checked above. A photocopy of this authorization shall be as valid as the original. I agree that all information provided in this document is accurate and complete to the best of my knowledge. I understand that any incorrect or undisclosed information can result in duplicate payments creating a substantial overpayment. Such overpayment will be the obligation of the undersigned, with responsibility to reimburse in full, upon request, all amounts deemed refundable. I also authorize the Insurance Company checked above or their 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 the Insurance Company from liability as to amounts so paid. **Any Person who intentionally includes false or misleading information in an attempt to defraud or deceive is guilty of a crime. I hereby CERTIFY that I have read the answers to all parts of this form and to the best of my knowledge and belief the information is complete and correct as given herein.**

Signature:_____ Date: _____
(Please Print, Sign and Date Completed Claim Form)