

College Accident Claim Form

Life Insurance Company of North America
CIGNA Life Insurance Company of New York



For Office Use Only

Policy Number
Reference Number
Coverage Code

Complete both sides of this form. Attach bills and insurance payment records.

Mail to: Preferred Care
1300 Virginia Drive
Suite 315
Ft. Washington, PA 19034
Telephone: 1-800-222-3085

FRAUD WARNING: Any person who, knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act. *For residents of the following states, please see page 3: California, Colorado, District of Columbia, Florida, Kentucky, Maryland, Minnesota, New Jersey, New York, Oregon, Pennsylvania, Tennessee, Texas or Virginia.*

CLAIM FORM INSTRUCTIONS

- Part I - Must be completed by school official if accidental injury occurs during a sponsored or supervised activity. If accidental injury does not occur during a sponsored or supervised activity, Part I of claim form should be completed by the claimant - or by the parent or guardian if the claimant is a minor (under 18 years of age).
- Part II - Must be completed by the claimant or by the parent or guardian if the claimant is a minor.
- Part III - Must be completed by physician or dentist providing treatment or services.
- The claim must be submitted within 90 days from the date of injury and the first expense must be incurred within 30 days from the date of injury.
- Attach itemized bills showing diagnosis, treatment, dates of treatment, and charges with corresponding explanation of benefits statement to this claim form. Forward all additional bills with record of payment from your primary insurance.
- Please note the name of the school district on all bills and correspondence.
- All benefits will be made payable to the physicians and providers involved, unless accompanied by paid receipts.

PART I - COLLEGE/UNIVERSITY REPORT

1. Name of College/University JOLIET JUNIOR COLLEGE			2. Address 1215 Houbock Road, Joliet, Illinois 60431				
3. Name of Insured	Last	First	Middle initial	4. Social Security No.	5. Grade	6. Birthdate	7. Sex
8. Nature of Injury (Please describe, fully indicating what part of body was injured - e.g. broken arm, sprained ankle, etc.) DO NOT COMPLETE AT THIS TIME							
9. Describe how accident occurred. (Give all possible details.) MUST BE A BODILY INJURY DUE TO ACCIDENT. DO NOT COMPLETE AT THIS TIME							
10. Did Accident occur:		Yes	No	11. a) Date of Accident:		12. Name of Activity	
a) While claimant was school supervised?		<input type="checkbox"/>	<input type="checkbox"/>	b) Time:		13. Name and Title of Supervisor DO NOT COMPLETE AT THIS TIME	
b) During school sponsored activity?		<input type="checkbox"/>	<input type="checkbox"/>	c) Place:			
c) During programmed school hours?		<input type="checkbox"/>	<input type="checkbox"/>	DO NOT COMPLETE			
d) On activity premises?		<input type="checkbox"/>	<input type="checkbox"/>	14. Signature of School Officer		15. Title	
e) While traveling directly and uninterruptedly to or from home premises and school for regular school sessions or school sponsored and supervised activities?		<input type="checkbox"/>	<input type="checkbox"/>	ATHLETIC TRAINER		16. Date	
f) Off school premises, at home, during the weekend, holiday, or summer vacation?		<input type="checkbox"/>	<input type="checkbox"/>				

NO CLAIM WILL BE PROCESSED UNLESS ALL INSTRUCTIONS ARE FOLLOWED AND FORM IS COMPLETED IN FULL.

PART II - TO BE COMPLETED BY CLAIMANT - OR BY PARENT IF CLAIMANT IS A MINOR

1. Name of Father or Guardian		2. Social Security No.	
3. Name of Mother or Guardian		4. Social Security No.	
5A. Address of Parents or Guardian/or Claimant		5B. Telephone Number	
6A. Father or Guardian's Insurance Company		Check One: <input type="checkbox"/> Individual	6B. Mother or Guardian's Insurance Company
		<input type="checkbox"/> Group	Check One: <input type="checkbox"/> Individual
			<input type="checkbox"/> Group
7A. Name and Address of Father or Guardian's Employer		7B. Name and Address of Mother or Guardian's Employer	
8. List other insurance policies under which claimant is insured:		Policy No.	<input type="checkbox"/> Individual
a. Company:			<input type="checkbox"/> Group
b. Other School Insurance:		Policy No.	<input type="checkbox"/> Individual
			<input type="checkbox"/> Group
9. Is the claimant enrolled in, a member of, or a participant of any of the following as an individual, employee, or dependent?			
a. Preferred Provider Organization (PPO) or similar health care plan?		<input type="checkbox"/> Yes <input type="checkbox"/> No	Policy No. _____
If yes, name of PPO or Organization _____			
b. Health Maintenance Organization (HMO) or similar prepaid health care plan?		<input type="checkbox"/> Yes <input type="checkbox"/> No	Policy No. _____
If yes, name of HMO or Organization _____			
10. If claimant has health care coverage as a dependent from a previous marriage as mandated in a divorce decree, please provide the following:			
Name of Insurance Company _____		Policy No. _____	
Name of Policyholder _____			

AUTHORIZATION TO RELEASE INFORMATION

I authorize any Health Care Provider, Insurance Company, Employer, 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 any CIGNA company, the Plan Administrator or their employees and authorized agents for the purpose of validating and determining benefits payable. This data may be extracted for use in audit or statistical purposes. I understand that I or my authorized representative will receive a copy of this authorization upon request. This authorization or a photostatic copy of the original shall be valid for the duration of the claim.

Signature (Parent or guardian if claimant is a minor)	Date	Phone No.
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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.

Signature (Parent or guardian if claimant is a minor)	Date
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