PROOF OF CLAIM

There is a timely filing period of one year and ninety days. Do not wait to send information as this may result in claim denial.

Email, Fax or 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. A school official must complete and sign PART A*.
2. The student's parent or guardian must complete PART B.
3. See Page 2 for important claim procedures.

TO BE COMPLETED BY A SCHOOL OFFICIAL

PART A: NOTICE OF INJURY

1. Name of School _____ School District Name _____

   School Address _____ (City) (State) (Zip)

2. Name of Student _____ Grade _____

3. 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:

INTERSCHOLASTIC SPORTS

☐ Practice ☐ Travel to/from Sport
☐ Game
What Sport? _____

NON-INTERSCHOLASTIC SPORTS

☐ Travel to/from School ☐ Non-school activity
☐ In classroom ☐ Physical Education
☐ Other - Activity _____
☐ On school grounds

6. Part of the body injured _____ ☐ Left ☐ Right

7. Describe in detail how and where the injury occurred _____

_____

_____

_____

Reported by _____
(Signature of School Official) (Title) Date(mm/dd/yyyy)

(*Part A may be completed by the parent if Full-Time Coverage was purchased.)
IMPORTANT INFORMATION ON Page 2

TO BE COMPLETED BY A PARENT OR GUARDIAN

PART B: PARENT STATEMENT

1. Students Name _____ Date of Birth _____
   Date (mm/dd/yyyy)

   Students Social Security # _____ - _____ - _____

   Parents Name _____ Relationship to Insured _____

   Mailing Address _____
   (Street, Route, or Box) (City) (State) (Zip)

2. Home phone number _____

3. Father's Occupation _____ Employer _____

   Mother's Occupation _____ Employer _____

4. Do you have insurance coverage? ☐ Yes ☐ No Is the student covered under your insurance plan? ☐ Yes ☐ No

   Name of Insurance Company _____

   ☐ Group ☐ Individual ☐ Medicaid ☐ CHIP ☐ None

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. By entering my name below, I am indicating my intent to sign this claim form and warrant that all of the information provided is true, complete, and accurate.

_____ _____ _____
Date (mm/dd/yyyy) (Print Name of Student/Patient) (Signature of Parent or Guardian)