When Completed, return this form to the Plan Administrator:
Special Risk Claims
Commercial Travelers Life Insurance Co.
70 Genesee St., Utica NY 13502 • Toll Free: 800-756-3702

Underwriting Company:
National Guardian Life Insurance Company

IMPORTANT: Please attach itemized bills. This form MUST be completed in full and returned to the Company WITHIN 90 DAYS from the date of treatment accompanied by all itemized bills received to date. Mail to the address shown on the this form. Payments will be made to the service provider unless otherwise advised.
Notice: When we are the secondary plan, we do not pay until after the primary plan has paid its benefits if any. We will review Usual & Customary charges of each plan and allow the highest. Any amount paid by your primary plan for an eligible expense under our plan may satisfy all or a portion of our deductible.

□ Accident Only-2017M3B44 □ Student Health-2017M3B45 □ Intercollegiate Sports-2017M3B05

CLAIM CANNOT BE PROCESSED WITHOUT THIS INFORMATION

College (or) University: KENYON COLLEGE

□ International Student-Student ID# _____
□ Domestic Student-Soc. Sec. _____

Student's Name: _____ ☐ Female ☐ Male Date of Birth: _____

Student School Address: _____ Email Address: _____
Street Address City State Zip

Student Mailing Address: _____ Telephone: ( ) _____
Street Address City State Zip

1. Date of Injury (or) onset of sickness: _____ When was physician First Consulted? _____
   Nature of Illness (or) Injury : _____ Part of Body Injured: ☐ Left ☐ Right
   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
   Club Sport? ☐ Yes ☐ No If "Yes", name sport _____
   (c) IF AN INTERCOLLEGIATE ACCIDENT, THIS FORM MUST BE SIGNED BY THE UNIVERSITY HEALTH CENTER
   I certify the above accident resulted from the supervised practice or play or travel to and from an intercollegiate sport

   _____
   Signature of University Health Center Official Title Date

2. Were you treated and/or referred by the University Health Center? ☐Yes ☐ No If "Yes", date: _____
3. Hospital (Give name, address and date of confinement) _____
   _____
4. Give names, addresses and telephone numbers of all attending physicians _____
   _____
5. Give name, address and telephone number of usual family physician _____
   _____ Phone _____
6. Have you suffered same or similar condition in the past? ☐ Yes ☐ No If "Yes" and you were treated for it, please give name & Address of the physician who treated you _____
   Dates treated _____
   If hospitalized at that time: Name of hospital _____
   Address _____ Dates Confined _____
7. Was Injury the result of a motor vehicle accident? ☐ Yes ☐ No
8. Are you employed full-time? ☐ Yes ☐ No If yes, Employers Name _____
   Employers Address _____ Employers Phone Number _____
9. Do you, your spouse or your parents have other insurance or medical plan which covers this condition, either group, individual, automobile, medical or liability?
   ☐ Yes ☐ No If so, give name of Company: _____
10. _____
    Name of Parent #1 SS# Father's Employer Name Address Employer's Phone #
11. _____
    Name of Parent #2 SS# Mother's Employer Name Address Employer's Phone #
12. _____
    Spouse's Name SS# Spouse's Employer Name Address Employers Phone #

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 stated above or its authorized benefit Plan Administrator. A photostatic of this authorization shall be as valid as the original.
I also authorize the Insurance Company stated 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 knowingly, and with intent to defraud, injure or deceive any insurance company, files or causes to be filed, a claim for payment of a loss, containing any false or incomplete information commits a fraudulent insurance act that may be a crime and may subject such person to confinement in prison, fines and denial of benefits.
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.

Name of Student _____ Date _____

Signature of claimant (parent or guardian if not adult) _____

Student's Address While at School _____
Street City State Zip