Student Accident Claim Form

National Association for the Education of Young Children

TO BE COMPLETED BY LEADER OR OTHER OFFICIAL

Mail To:
Fidelity Security Life Insurance Company
3130 Broadway
Kansas City, MO 64141-9131

SECTION I

Policy Number	Policy Period	Name and Location of Agent
FH315-5592	CONTINUOUS - ANNUAL	

Name of School or Organization (if Sportsteam, give Name of League and Team) DONA ANA HEAD START

Address of School or Organization PO Box 30001 Dept 3R Las Cruces, NM 88003

Name and Address of Student Member or Camper	Date of Birth	Age

Name and Address of Hospital	Date Entered Hospital

Name and Address of Attending Physician

DUE TO ACCIDENT	Date and Time of Accident	Place of Accident
	Nature of Injury	
	What Caused the Accident?	
	Describe Type of Sport or Activity Engaged in at Time of Accident	
	Name of Supervisor of the Activity	
	Witness to Accident (Name and Address)	
DUE TO ILLNESS	Nature of Illness	Date Illness Commenced

I hereby certify that the above is a member of the group insured under Policy No. FH315-5592 and that the above injury or sickness was sustained while participating in official activities under adequate organizational supervision. If a scouting group, give date of member's registration with Council. _____ 19____

TITLE OF OFFICIAL _____ OFFICIAL'S SIGNATURE _____

ADDRESS _____ DATE _____ 19 _____

SECTION II

TO BE COMPLETED BY CLAIMANT

To whom are payments to be made? ☐ Claimant ☐ Doctor ☐ Hospital

Address of ☐ Claimant ☐ Doctor ☐ Hospital

Are there Medical Benefits available from any other source? ☐ Yes ☐ No. If yes, specify nature of other policy or plan and name of insurer or organization from whom benefits are available _____

COMPLETE ONLY IF CLAIMING DISABILITY BENEFITS	Date Total Disability Began _____ 19____ ☐ A.M. ☐ P.M.	Date Total Disability Ended _____ 19____ ☐ A.M. ☐ P.M.
	Normal Occupation	Duties Unable to Perform
	Name and Business Address of Employer	

I hereby authorize any physician who has attended me or any hospital where I may have been a patient, or any other individual or association who may have given me medical treatment or supplies to disclose any information thus acquired. My consent is hereby granted to use this original or a photostatic copy as equally valid authorization. NOTE TO ALL PARTIES COMPLETING THIS FORM: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURANCE COMPANY, SUBMITS AN APPLICATION, FILES A STATEMENT OR CLAIM CONTAINING ANY FALSE , INCOMPLETE OR DECEPTIVE INFORMATION IS GUILTY OF FELONY INSURANCE FRAUD. CRIMINAL AND/OR CIVIL PENALTIES CAN RESULT FROM SUCH AN ACT.

Patient's signature--if claim is for other than minor child	Date
Signature of Parent--if claim is for minor	Date

ITEMIZED BILLS FOR HOSPITAL AND MEDICAL TREATMENT MUST BE ATTACHED HEREWITH.

Attending Physician Must complete the Reverse Side of this Form.

ATTENDING PHYSICIAN'S STATEMENT -- HEALTH INSURANCE CLAIM

SECTION III

Patient's Name and Address | Age

Diagnosis and Concurrent Conditions (If Fracture or Dislocation, Describe Nature and Location)	
When did symptoms first appear or accident happen?	Date.....19.....
When did patient first consult you for this condition?	Date.....19.....
Has patient ever had same or similar condition? (If "Yes", state when and describe)	Yes☐ No☐
Nature of Surgical Procedure if any. *(Describe Fully)*	Date Performed.....19.....
Charge to patient for this procedure including post-operative care	$.....
If performed in hospital, give name of hospital	Inpatient☐ Outpatient☐
Give dates of other medical (non-surgical) treatment, if any.	Charge Per Call Office.....$..... Home.....$..... Hospital.....$..... Nursing Home.....$..... Total (Non-Surgical) Charges.....
What other services, if any, did you provide patient? (Itemize. Giving Dates and Fees)	
Were registered private duty nurse (R.N.) services necessary?	Yes☐ No☐
Is patient still under your care for this condition? If "No", give date your services terminated	Yes☐ No☐ Date 19
How long was or will patient be continuously totally disabled *(Unable to work)*?	From.....19..... Thru.....19.....
How long was or will patient be partially disabled?	From.....19..... Thru.....19.....
Was house confinement necessary? If "Yes" give dates	Yes☐ No☐ From.....19..... Thru.....19.....
To your knowledge does patient have other health insurance or health plan coverage? If "Yes" identify	Yes☐ No☐
Is condition due to injury or sickness arising out of patient's employment? If "Yes" explain.	Yes☐ No☐

(ANSWER ALL QUESTIONS ABOVE, IN addition TO THOSE BELOW, IF DENTISTRY)

State exactly which teeth were involved in the accident and indicate them on the chart: .....

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Describe exact nature of injury .....

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	8	7	6	5	4	3	2	1		1	2	3	4	5	6	7	8
U	☐	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐
				E	D	C	B	A		A	B	C	D	E			
				RIGHT				LINGUAL					LEFT				
				E	D	C	B	A		A	B	C	D	E			
L	☐	☐	☐	☐	☐	☐	☐	☐		☐	☐	☐	☐	☐	☐	☐	☐
	8	7	6	5	4	3	2	1		1	2	3	4	5	6	7	8

Describe condition of injured teeth prior to accident .....

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(State whether whole, sound and natural, filled, capped or artificial.)

REMARKS

Taxpayer Identification application to above charges. **Social Security No.** ☐☐☐–☐☐–☐☐☐☐ **Employer Identification No.** ☐☐–☐☐☐☐☐☐☐

Date | Signature (Attending Physician) | Degree | Telephone

Street Address | City or Town | State or Province | Zip Code

L186-21387 993