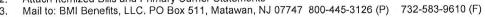
HOW TO FILE A CLAIM:

1. Complete this form within 90 days.

Attach Itemized Bills and Primary Carrier Statements





ANY PERSON WHO KNOWINGLY AND/OR WITH INTENT TO INJURE, DEFRAUD OR DECEIVE AN INSURANCE COMPANY OR OTHER PERSONS FILES A STATEMENT OF CLAIM CONTAINING FALSE, INCOMPLETE OR MISLEADING INFORMATION, MAY BE GUILTY OF INSURANCE FRAUD AND SUBJECT TO CRIMINAL AND SUBSTANTIAL CIVIL PENALTIES.

School/Organization					Policy#							
School Mailing Address					City, State, Z	ip						Ballacope or continue to the second of the text
njured Person's Name			Birth	date			Male	Femal	€ 🗆			
		T	vpe of Sport			Part of	body injured					Brown Company View
Date of Injury Time		')	pe of Sport			raitoi	body injured				aggerige weight prime the remaining comm	
low did Injury occur?												
Sport Designation: Interscholastic		ntramurals	s□ Practice		Gameุ □	Othe	er 🗆					
At the time of the injury, was the in	jured invo	olved in an	activity sponsore	d and	supervised by	the police	cy holder?	YES 🗆	NO 🗆			
Name of Supervisor				Was I	he/she a witne	ess to the	accident?	YES 🗆	NO 🗆			
Signature of Supervisor/Official				Title	ř			Date				
THE INJURED PERSON'S	-	L SECU	PART 1 B RITY NUMBER	: INJU MUS	JRED PERS T BE PROV	SON'S I VIDED A	NFORMAT AS REQUIR	TION RED BY	THE CEN	ER FOR	MEDICAR	E SERVICES
Injured Person's Home Address(Street, Ci	ty, State, 2	Zip)								a kalanan karangan kalana da karan	Augustus III yriden ddogwyr yw chanta trei ddiwyr ddogwyr ddiwydd y chantaeth
Is the injured Person Employed?	YES 🗆	NO 🗆	If yes, please f	II out S	Section A belo	ow.						
Is the injured Person Married?	YES 🗆	NO 🗆	Spouse's Nam	9								
	YES 🗆	NO 🗆	If yes, please f	-								
Are you covered by any other insu If Yes: Name of Insurance Carrier	rance pol	icy, either	as a dependent,	group,	individual, au	ıtomobile	medical or I	iability YES olicy #:	S 🗆 NO			
			PAF	RENT	GUARDIAN	INFOF	RMATION	77.59 FIF (1)				ad v
Father/Guardian Name					Mother/Gua	rdian Nar	ne					
Address (Street, City, State, Zip)	gregori galigitas en en en el sem				Address (S	treet, City	, State, Zip)	3444 WOOD ST V ST V V	······································			
Home Phone					Home Phon	е						Page region of the second seco
Is the Father Employed? YES □	NO a				Is the Mothe	er Employ	/ed? YES o	NO 🗆				
SECTION A (INSURED/FATI	IER)	258	1.00		SECTION	B (SP	OUSE/MO	THER)		70 (m. 1941) 10 (m. 1941)		Harage,
Employer					Employer							
Address (Street, City, State, Zip)					Address (S	treet, City	y, State, Zip))				
Business Phone					Business P	hone						
Insurance Company		Policy#			Insurance C	Company		Pol	icy#			

tindings and treatment rendered, X-rays and copies of all hospital and medical records, all occasioned by professional services and hospital care rendered on my behalf. The foregoing authorization is granted with the understanding that any legal rights I may ordinarily have to claim communications between us as privileged are hereby expressly and voluntarily waived. A Photostat of this authorization shall be considered as effective and valid as the original, PAYMENT WILL BE MADE TO THE PROVIDERS OF SERVICE (HOSPITAL, PHYSICIAN AND OTHERS), UNLESS A PAID RECEIPT OR STATEMENT ACCOMPANIES THE BILL AT THE TIME THE CLAIM IS SUBMITTED.

New York: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.