

CLM#

D. _____
H. _____
P. _____

PLAN	PAY
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DATE PREM. PD. _____
AMOUNT PD. _____
DATE PD. OR DECL. _____

THIS SPACE FOR COMPANY USE ONLY

MARICOPA COUNTY COMMUNITY COLLEGE DISTRICT

POLICY NO. 024-111-004-P

NAME OF SCHOOL _____

ADDRESS _____

AUTHORIZED SIGNATURE _____

**IMPORTANT!
THIS INFORMATION
MUST BE GIVEN
OR CLAIM WILL
BE RETURNED**

GUARANTEE TRUST LIFE INSURANCE COMPANY
Personal Insurance Administrators, Inc.
P.O. Box 5004
Thousand Oaks, CA 91359-5004
1-800-468-4343

TITLE _____

PRINT NAME _____

Name of Student _____ S.S. No./ID No. _____ Date of Birth _____ Age _____

Permanent Home Address _____
Number and Street _____ City _____ State _____ Zip Code _____

School Address _____
Street or RFD _____ City and State _____ Zip Code _____

Name of Dependent _____ S.S. No./ID No. _____ Date of Birth _____ Age _____

Permanent Home Address _____
Number and Street _____ City _____ State _____ Zip Code _____

YOUR CLAIM WILL BE RETURNED IF THIS SECTION IS NOT FULLY COMPLETED

1. Date of injury or beginning of sickness. _____ 20 _____ Time _____

2. Nature of injury or sickness. _____

3. If injury, describe how and where accident occurred. Give complete details. _____

4. If injured during supervised intercollegiate practice or play of sport, trainer must certify with signature. Name Sport _____ Check One: Intramural Intercollegiate Other

5. Have you suffered same or similar condition before? (If previously treated for it, give name and address of physician and name of hospital.) Yes No If yes, when _____

6. Date confined to hospital. From _____ To _____
Name and address of hospital. _____

7. Name and address of physician _____

8. Has treatment been completed? Yes No If no, give details _____

9. Do you have other insurance which covers this condition, either group, individual, automobile medical or liability? Yes No Self Parent's
If yes, give name of company _____

If covered under Parent's Insurance or if privately insured, please include the following information
Policy No. _____
Group No. _____
Phone No. of Insurance Co. _____

10. Parent's Name (Holder of Policy) Father _____ or Mother _____

Employer's Name _____

Employer's Address _____

S.S. No. _____

IMPORTANT:

PLEASE ATTACH ITEMIZED BILLS

THIS FORM MUST BE COMPLETED AND RETURNED TO THE COMPANY WITHIN 90 DAYS FROM THE DATE OF TREATMENT ACCOMPANIED BY ALL BILLS INCURRED TO THAT DATE.

AUTHORIZATION: I hereby authorize Guarantee Trust Life Insurance Company, or its representative, to inspect or secure copies of case history records, laboratory reports, diagnosis, prognosis, x-rays, and any other data covering this and /or previous confinements and/or disabilities. A photostatic copy of this authorization shall be deemed as effective and valid as the original.

I hereby authorize the Guarantee Trust Life Insurance Company to pay bills in connection with this claim directly to the Doctor, Hospital or Other Payee indicated.

DATE _____ SIGNATURE OF STUDENT _____

For your protection, California Law requires that the following appear on this form: "Any Person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison."

ASSIGNMENT OF BENEFITS

PARENT (OR CLAIMANT, IF ADULT) MUST COMPLETE IN FULL INDICATING TO WHOM PAYMENT IS TO BE MADE. (PLEASE PRINT.)

Dr.: _____ Hosp.: _____ Other: _____

Address _____
City _____ State _____

Address _____
City _____ State _____

Address _____
City _____ State _____

AUTHORIZATION: I hereby authorize GUARANTEE TRUST LIFE INSURANCE COMPANY, or its representatives, to inspect or secure copies or case history records, laboratory reports, diagnosis, prognosis, and any other data covering this and/or previous confinements and/or disabilities.

DOCTOR, PLEASE SIGN: _____ DATE: _____

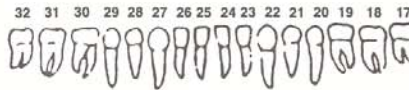
ATTENDING PHYSICIAN'S STATEMENT EACH DOCTOR'S BILL ATTACHED MUST BEAR THE DOCTOR'S I.D. OR SOCIAL SECURITY NUMBER.
This Statement MUST Be Completed

Patient's Name _____	S.S. No./ID No. _____	Date of Birth _____	Age _____
1. Nature of sickness or injury. (Describe complications, if any)	Diagnostic ICD Code _____		
2. If a fracture or dislocation, state whether reduced or immobilized. If fracture of long bones, state whether fracture is through shaft or extremity. Was it confirmed by X-ray?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
3. When did symptoms first appear or accident happen?	Date _____, 20__		
4. When did patient first consult you for this condition?	Date _____, 20__		
5. Has patient ever had same or similar condition? (if "Yes," state when and describe)	<input type="checkbox"/> Yes <input type="checkbox"/> No		
6. Describe any other disease or infirmity affecting present condition.	_____		
7. Nature of surgical or obstetrical procedure, if any. (Describe fully) Where and when performed?	Date _____ if in hospital, in patient <input type="checkbox"/> out patient <input type="checkbox"/>		
8. Give dates of treatment.	_____		
9. If patient referred by other doctor, give name and address of such doctor.	_____		
10. Is patient still under your care for this condition? If discharged, give date.	<input type="checkbox"/> Yes <input type="checkbox"/> No Date _____, 20__		
11. If patient hospitalized, give name and address of hospital.	Hospital: _____ Date Admitted _____, 20__	City: _____ Date Discharged _____, 20__	State: _____
12. Did you file this claim with any other insurance company? If "Yes," indicate name, address and phone number of the company on the front.	<input type="checkbox"/> No Name of insured _____ <input type="checkbox"/> Yes S.S. No. of insured _____ Policy # _____		

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

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





2. Describe exact nature of injury: _____

3. Describe condition of injured teeth prior to accident:

Whole, sound and natural Filled Capped Artificial

4. Comments: _____

SIGNED: _____ DEGREE: _____ DATE: _____

I.D. or S.S. No. _____ Must be filled in.

ADDRESS: _____ CITY AND STATE _____

IMPORTANT: This form **MUST** be completed and returned **WITHIN 90 DAYS** from the date of treatment accompanied by all bills incurred to that date.