SCHOOL'S REPORT OF ACCIDENT

Complete this form and return within 90 days of the accident. Please send **itemized** bills only; balance due bills cannot be processed. Only one form is necessary per accident. Show school name and policy number on additional bills

GOODWIN & GRUBER AGENCY
300 McKNIGHT PARK DRIVE
PITTSBURGH, PA 15237-6534
(412) 366-5080

Name of School _____ Policy No. _____ Student's Social Security Number

School System _____ Name of Student _____

Student covered: ☐ Schooltime ☐ 24 Hr. ☐ Dental ☐ All Sports ☐ Football Student's Birthdate _____ Grade _____

Name and Address of Parent or Guardian _____

1. Date of Accident _____ Time _____ ☐ AM ☐ PM Phone _____
2. COMPLETE details of accident _____
3. Nature of injury _____
4. Did accident occur while:
   (a) Attending school during hours and days school in session? ☐ No ☐ Yes ; on Home premises? ☐ No ☐ Yes
   (b) Traveling to or from School? ☐ No ☐ Yes If yes, was student on usual and direct route? ☐ No ☐ Yes
   (c) Engaged in a school sponsored and supervised activity? ☐ No ☐ Yes If yes, name and place of activity _____
   (d) Was student participating in an intramural (☐ Yes ☐ No) or **interscholastic** (☐ **Yes** ☐ **No**) sport? What sport? _____
5. Names and addresses of attending physicians _____

I hereby certify that the above answers are complete, true, and correct to the best of my knowledge and belief.

SIGNATURE OF SCHOOL OFFICIAL _____ Title _____ Date _____
(Required on all claims except 24 hour coverage)

SIGNATURE OF PARENT OR GUARDIAN _____ Date _____
(Parent please complete reverse side of claim form)

This Section Must Be Completed by Parent or Guardian

IF BLUE CROSS (HOSPITALIZATION) GROUP # CONTRACT # SERVICE CODE #	IF BLUE SHIELD (PHYSICIAN'S CARE) GROUP # CONTRACT # SERVICE CODE #
NAME AND ADDRESS OF MOTHER'S EMPLOYER	NAME AND ADDRESS OF FATHER'S EMPLOYER

DO YOU HAVE MEDICAL INSURANCE OTHER THAN BLUE CROSS?	IF SO, NAME OF COMPANY	POLICY NUMBER
ADDRESS OF OTHER INSURANCE COMPANY NAMED ABOVE		TYPE OF PLAN FROM THIS COMPANY ☐ Individual ☐ Group

AFFIDAVIT

I verify that the above statement on other insurance is accurate and complete. I understand that the intentional furnishing of incorrect information via the U.S. Mail may be fraudulent and violate federal laws. I agree that if it is determined at a later date that there are other insurance benefits collectible on this claim I will reimburse the insurance company named on the reverse side of this form to the extent of any amount collectible.

SIGN: Parent or Guardian _____ Date _____

please complete AUTHORIZATION below and return immediately to eliminate any delay in completion of claim.

AUTHORIZATION

I authorize any physician and/or hospital to release such information as relates to this claim to The Insurance Company or the Company's authorized Claims Administrator.

Signature _____ Date _____

AUTHORIZATION TO PAY BENEFITS TO PROVIDER

I authorize payment of Medical payments to Physician or Supplier for Services described on the reverse side.

SIGN: Parent or Guardian _____ Date _____

Pennsylvania Residents: Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or 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 subjects such person to criminal and civil penalties.

PHYSICIAN'S OR DENTIST'S REPORT (Required on Dental Claims).

1. Nature of Injury _____

2. Date of First Treatment _____

3. Has patient ever had the same or similar condition? ☐ No ☐ Yes . If yes, state when and describe _____

4. Nature of Surgical Procedure, if any & procedure code _____

5. Dates of Treatment _____ Description _____ Charge _____

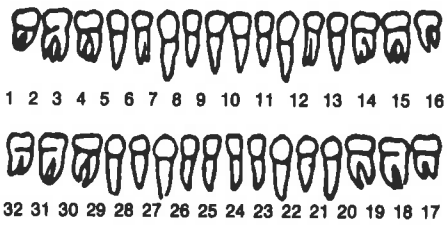
TOTAL _____

6. Has patient been discharged from treatment? ☐ No ☐ Yes . If yes, give date _____

7. Was patient confined to hospital? ☐ No ☐ Yes . If yes, give name and address of hospital and dates confined _____

8. **TO WHAT OTHER INSURANCE COMPANY HAVE YOU REPORTED THIS CLAIM?** _____
Name
_____
Address

9. List below teeth involved and indicate on chart.



CO. USE ONLY

10. Describe Condition of Injured Teeth Prior to Accident.

1. CARIOUS ☐
2. FILLED ☐
3. WHOLE ☐
4. CAPPED OR ARTIFICIAL ☐
5. SOUND AND NATURAL ☐

NOTICE OF A LEGAL REQUIREMENT—Please insert your Tax Identification No. as required by Section 6041 of the Internal Revenue Code.
CLAIM CANNOT BE PROCESSED WITHOUT THIS INFORMATION.

PHYSICIAN'S SIGNATURE _____ **DATE** _____

PHYSICIAN'S NAME AND ADDRESS _____
Name (Please print or type) Address

HOSPITAL REPORT—Attach Itemized Hospital Bill, If Any.

PLEASE ATTACH ITEMIZED BILLS

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