

UNITED STATES FIRE INSURANCE COMPANY

By Fairmont Specialty, a Division of Crum & Forster
Eatontown, New Jersey

Claim Instructions

*Attach itemized bills, showing treatment, and dates of treatment and charges to the claim form, forward additional bills to the above address. *Do not leave claim form at hospital. *Payment Will be made to the doctor or hospital, etc., unless a paid receipt or statement is attached. * No additional claim form is necessary.

MAIL TO:

T.W. LORD & ASSOCIATES
P.O. BOX 1185
MARIETTA, GA 30061
PHONE 1-800-633-2360

It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/ or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

To Be Completed By Claimant		SOCIAL SECURITY NUMBER	
_____		_____	
Claimant's Name _____	Date of Birth _____	Male _____	Female _____
Last Name	First Name		
Present Address _____			
No. & Street	City or Town	State	Zip
Dependent's Name _____	Phone Number _____	email address _____	

Date of accident or sickness _____

Nature of sickness or injury _____

If injury, describe fully how and where accident occurred _____

If Injured in Play or Practice of Sport
Indicate What Sport
Check One: Intramural Inter Collegiate Club

Have you ever had the same or similar symptoms _____ Yes _____ No _____ If so, when? _____

Were you treated at the Student Health Services?
_____ Yes _____ No _____ If so, When? _____

Name and Address of Physician _____

Give names of all other Physicians consulted _____

Hospitalized _____ From: _____ To: _____

Name and Address of Hospital _____

Are you covered by any other medical insurance policy? Yes _____ No _____ if Yes, Please provide name and address of other Insurance Company. _____

Policy Number: _____

AUTHORIZATION TO OBTAIN MEDICAL INFORMATION

TO: Any medical professional, hospital or other medical-care institution, insurance support organization, pharmacy, governmental agency, insurance company, group policyholder or benefit plan administrator.

I AUTHORIZE you to release to the UNITED STATES FIRE INSURANCE COMPANY or its representatives, PROFESSIONAL CLAIMS ADMINISTRATORS, INC. any and all information concerning advice, care or treatment provided the patient, or deceased, including information relating to mental illness, use of drugs or use of alcohol. I also authorize the group policyholder or benefits plan administrator to provide to the UNITED STATES FIRE INSURANCE COMPANY or its representatives, PROFESSIONAL CLAIMS ADMINISTRATORS, INC. with insurance coverage information including benefits paid or payable, financial information or employment related information. I UNDERSTAND that the information released under this authorization will be used for the purpose of evaluating and processing a claim for benefits. I authorize the UNITED STATES FIRE INSURANCE COMPANY, or its representatives, PROFESSIONAL CLAIMS ADMINISTRATORS, INC. to disclose the information for that purpose to the group policyholder or its representatives, to any reinsurer, and to any other insurer or self-insurer to whom a claim for benefits may be submitted. This disclosure will include benefits paid or copies of checks/drafts.

I also AUTHORIZE the UNITED STATES FIRE INSURANCE COMPANY, or its representatives, PROFESSIONAL CLAIMS ADMINISTRATORS, INC. to disclose the information to any person performing a business or legal function for its benefit, and to any person who has an authorization specifically permitting the disclosure.

I AGREE that the authorization shall be valid from the date signed for one full year.

I know that I have a right to request to receive a copy of this authorization. A photocopy of this authorization shall be as valid as the original.

Signature of Patient

Date Signed