



Policy Name:

YUBA COMMUNITY COLLEGE DISTRICT

Policy Number:

MAR16735

School Name (if applicable):

- 1. PLEASE FULLY COMPLETE THIS FORM
- 2. ATTACH ITEMIZED BILLS
- 3. MAIL TO HSR
- E-mail : claims@hsri.com

HSR Plaza II
 4100 Medical Parkway
 Carrollton, Texas 75007
 Phone: (972) 512-5600 Fax: (972) 512-5820
 Toll Free (800) 328-1114

PART I – POLICYHOLDER’S REPORT

1. Claimant’s Name (Injured Person)		2. Social Security Number	3. Gender <input type="checkbox"/> M <input type="checkbox"/> F	4. Date of Birth	5. E-Mail
6. Address of Injured Person and Best Contact Phone Number (Include Area Code)					
7. If Applicable, Parent’s Name, Address, and Best Contact Phone Number (Include Area Code)					
8. Date and Time of Accident		9. Place where Accident Occurred		10. The injured person was a: <input type="checkbox"/> Participant <input type="checkbox"/> Staff Member <input type="checkbox"/> Guest <input type="checkbox"/> Volunteer	
Dental Claims	11. Indicate which Teeth were Involved in the Accident		12. Describe Condition of Injured Teeth Prior to Accident: <input type="checkbox"/> Whole, Sound, and Natural <input type="checkbox"/> Filled <input type="checkbox"/> Capped <input type="checkbox"/> Artificial		
13. Type of Injury (Indicate Part of Body Injured – e.g. broken arm, sprained ankle, etc.)				Did Injury Result in Death? <input type="checkbox"/> YES <input type="checkbox"/> NO	
14. Describe How Accident Occurred – Give All Possible Details					
15. Did Accident Occur (Check Yes or No for Each of the Following):					
A. During a policyholder programmed, sponsored & supervised, or sanctioned activity?		<input type="checkbox"/> YES <input type="checkbox"/> NO			
B. On activity premises?		<input type="checkbox"/> YES <input type="checkbox"/> NO			
C. While on the job (if applicable)?		<input type="checkbox"/> YES <input type="checkbox"/> NO			
D. While traveling directly and uninterruptedly to or from home and policyholder premises?		<input type="checkbox"/> YES <input type="checkbox"/> NO			
E. During intercollegiate/scholastic athletic practice?		<input type="checkbox"/> YES <input type="checkbox"/> NO		or competition? <input type="checkbox"/> YES <input type="checkbox"/> NO	
16. Name of Event or Activity			17. Name and Title of Supervisor		
18. Name of Policyholder					
20. Signature of Policyholder Representative			21. Title of Policyholder Representative		22. Date

PART II – OTHER INSURANCE STATEMENT

Do you/spouse/parent have medical/health care or is the Claimant enrolled as an individual, employee or dependent member of a Health Maintenance Organization (HMO) or similar prepaid health care plan, or any other type of accident/health/sickness plan coverage through your employer or other source on you or does your son/daughter have health care coverage as a dependent from your previous marriage as mandated in a divorce decree? YES NO

If Yes, name of insurance company _____ Policy # _____

Name of insurance company _____ Policy # _____

Claimant’s primary employer name, address, and phone number _____

Mother’s primary employer name, address, and phone number _____

Father’s primary employer name, address, and phone number _____

IF OTHER INSURANCE OR HEALTH CARE PLANS EXIST, PLEASE SUBMIT COPIES of their EXPLANATION OF BENEFITS along with your claim. IF NO OTHER INSURANCE or HEALTH PLAN EXISTS, PLEASE READ & SIGN BELOW.

I agree that should it be determined at a later date there is insurance (or similar), to reimburse **HEALTH SPECIAL RISK, INC.**, or the insurance company to the extent of any amount collectible.

SIGNATURE OF PARTICIPANT OR PARENT	DATE
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PART III – AUTHORIZATION TO PAY BENEFITS TO PROVIDER

I authorize medical payments to physician or supplier for services described on any attached statements enclosed. (if not signed, submit proof of payment)

SIGNATURE _____ DATE _____

I hereby authorize any insurance company, hospital, physician or other person who has attended or examined the claimant to disclose when requested to do so, all information with respect to any injury, policy coverage, medical history, consultation, prescription or treatment, and copies of all hospital or medical records. A photo static copy of this authorization shall be considered as effective and valid as the original.

SIGNATURE _____ DATE _____