PROOF OF CLAIM

This form should be completed and submitted to the Company within 90 days from date of injury.

Mail completed form to:
STUDENT ASSURANCE SERVICES, INC.
P.O. BOX 196
STILLWATER, MINNESOTA 55082

NOTICE: *Anyone who knowingly misrepresents or falsifies essential information requested by this form may upon conviction be subject to fine or imprisonment.*

CLAIM PROCEDURE:

1. A school official must complete PART A*.
2. The Insured's parents or guardian must complete PART B.
3. If dental charges — have statement completed on back.
4. See reverse side for important claim procedures.

TO BE COMPLETED BY A SCHOOL OFFICIAL

PART A: NOTICE OF INJURY

1. Name of School _____ School District Name _____
   School Address _____
   (City) (State) (Zip)
2. Name of Insured _____ Grade _____
3. Date of Injury _____ ☐AM ☐PM
4. Under whose supervision? _____ Was he/she a witness? _____
5. The accident was incurred while the Insured was participating in:

INTERSCHOLASTIC SPORTS

( ) Practice
( ) Game
( ) Travel

What sport? _____

NON-INTERSCHOLASTIC SPORTS

( ) Travel to/from school
( ) In classroom
( ) Physical Education
( ) On school grounds
( ) Non-school activity
( ) Other – Activity? _____

6. Part of the body injured _____ ☐R ☐L
7. Describe in detail how and where the injury occurred _____

Reported by _____
(Signature of School Official) (Title) (Date)

(*Part A may be completed by the parent if Full-Time Coverage was purchased.)
IMPORTANT INFORMATION ON REVERSE SIDE

TO BE COMPLETED BY A PARENT OR GUARDIAN

PART B: PARENT STATEMENT

1. Students Name _____ Birthdate _____
   Students Social Security # ☐☐☐-☐☐-☐☐☐☐
   Parents Name _____ Relationship to Insured _____
   Mailing Address _____
   (Street, Route, or Box) (City) (State) (Zip)
2. Home phone number _____
3. Father's Occupation _____ Employer _____
   Mother's Occupation _____ Employer _____
4. List your family or group coverage, please.
   Name of Insurance Company _____ ☐Group ☐Individual ☐Policy No. _____
   Address _____
   (Street) (City) (State) (Zip)

I hereby authorize any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance company, or other organization, institution, or person that has any records or knowledge of the claimant's physical or mental health, to give the information to STUDENT ASSURANCE SERVICES, INC. To facilitate rapid submission of such information, I authorize all said sources, to give such records or knowledge to any agency employed by the insurance company to collect and transmit such information. A photocopy of this authorization shall be as valid as the original. This authorization expires one year from the date signed.

_____ (Date) _____ (Print Name of Student/Patient) _____ (Signature of Parent or Guardian)