

Houston Area: 281-651-8787 Outside Houston: 800-285-8133

SPECIAL NOTICE: Any person who knowingly and with intent to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

**COMPLETE IN DETAIL
TO INSURE
PROMPT HANDLING**

- PLEASE PRINT ALL INFORMATION -
PART 1 – MUST BE COMPLETED AND SIGNED

Name of School		Group Number	Birth Date
Insured's Name		Insured's Social Security Number	Telephone Number
<i>Last Name</i>	<i>First Name</i>	<i>Middle Initial</i>	
Present Address			
<i>No. and Street</i>	<i>City or Town</i>	<i>State</i>	<i>Zip + 4</i>
Home Address			
<i>No. and Street</i>	<i>City or Town</i>	<i>State</i>	<i>Zip + 4</i>

If claim for dependent, give dependent's name: _____ Relationship to insured: _____ Date of Birth: _____

MUST BE COMPLETED	Are you covered (as an insured or dependent) by any other hospital and/or medical plan? <input type="checkbox"/> Yes-Insured <input type="checkbox"/> Yes-Dependent <input type="checkbox"/> No <i>(See below)</i> . If no, please state in sentence form "I have no other insurance". _____			
	If yes, please check one: <input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Automobile/Medical			
	If yes, also indicate name and policy number of Insurance Company.			
	<i>Name of Insured:</i>	<i>Policy#/Group#:</i>	<i>I.D. #</i>	<i>Company</i>
	Have you filed a claim with the above company? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I have no other Insurance			
Send copies of all Explanation of Benefits showing benefits paid (and/or benefits denied) to Guarantee Trust Insurance Company at the address at the top of this form.				
Name and address of Employer of:				
<input type="checkbox"/> Insured, if employed _____				
<input type="checkbox"/> Spouse, if insured is married (or has insurance coverage under a Domestic Partnership) _____				

1. Date of accident or sickness.		Date of first treatment.
2. Nature of sickness or injury.		
3. If injury, describe how and when accident occurred and indicate if work related.		
4. *If injured in play or practice of sport, indicate which sport.		Check one: <input type="checkbox"/> Intramural * <input type="checkbox"/> Intercollegiate <input type="checkbox"/> Other
5. Have you previously been troubled with this condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____	
6. Give names of all other physicians or health care providers consulted. (Attach separate page if needed)		
7. Hospitalized? If so, where and what date?	Where: _____	From: _____ To: _____
8. Student Health Center Referral?	<input type="checkbox"/> Yes If yes, attach referral to claim form. <input type="checkbox"/> No If no, please explain.	

PAYMENT WILL BE PAID TO THE PROVIDERS OF SERVICE (Hospital, Physician, and others), UNLESS A PAID RECEIPT OR PAID STATEMENT ACCOMPANIES THE BILL AT THE TIME THE CLAIM IS SUBMITTED.

***IMPORTANT** – If this claim is an INTERCOLLEGIATE SPORTS CLAIM, IT MUST BE SIGNED BY AN AUTHORIZED ATHLETIC/SCHOOL OFFICIAL

***Signature of Intercollegiate Athletic Official** _____ **Title** _____ **Date** _____

I hereby certify that the above injury was sustained while participating in official activities under adequate organizational supervision. Date _____.

TO ANY MEDICAL CARE PROVIDER, MEDICAL CARE FACILITY, INSURER, GOVERNMENT-SPONSORED HEALTH PLAN or EMPLOYER: I permit (while my claim is pending) the release of any medical information about me to Guarantee Trust Insurance Company and its representatives. Guarantee Trust Insurance representatives include re-insuring companies and other persons or groups performing business or legal services relating to my claim. This applies to all information about the diagnosis, treatment, or prognosis of any illness or injury I now have or have had in the past. Guarantee Trust Insurance Company will use this information to find out if my claim is eligible. A copy of this authorization (one of which will be given to me by Guarantee Trust Insurance Company upon my request) will be as valid as this one.

I certify that the above information given by me in support of this claim is true and correct.

Patient's or Authorized Representative's Signature _____ **Date** _____

If Authorized Representative, Relationship to Patient _____

(No. & Street) _____ (City/Town) _____ (State) _____ (Zip +4) _____

ITEMIZED BILLS FOR MEDICAL EXPENSES MUST BE ATTACHED.