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

Geographical Location_____ 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**