Global
CLAIMS ADMINISTRATION

Member of the Global Group of Companies
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ACCIDENT & SICKNESS INSURANCE CLAIM FORM

GROUP: Syracuse University **POLICY NUMBER: LF000041** **DATE:** _____

Name _____ Member ID # _____ Date of Birth _____

Current Home Address _____
Number and Street City State Zip Code Phone Number

Name of Dependent _____ Social Security # _____ Date of Birth _____

1. Date of injury or beginning of sickness _____ When was physician first consulted? _____
2. Work-related injury? ❑ Yes ❑ No Injury due to motor vehicle accident? ❑ Yes ❑ No
3. If injury, describe how and where accident occurred
   _____
   _____
4. Nature of injury or sickness _____
5. List all medications prescribed for this injury/sickness _____
6. Did injury occur during practice or play of sports? ❑ Yes ❑ No
   If yes, please check one of the following: ❑ Collegiate Varsity Team ❑ Collegiate Intramural/Club Team ❑ Recreational Sports Team
   ❑High School Varsity/Junior Varsity Team ❑ High School Intramural/Club Team ❑ Unofficial Sports Game
   Name of Sport _____ Signature of Athletic Trainer (If applicable) _____
7. Have you suffered same or similar condition before? ❑ Yes ❑ No
8. If you were previously seen please list dates treated and name and address of doctors who treated you: _____
   _____
   _____
   _____

Do you have other insurances: ***Group***: ❑ Yes ❑ No ***Individual***:❑ Yes ❑ No ***Automobile***:❑ Yes ❑ No ***Medical***: ❑ Yes ❑ No

If yes, who is the Holder of Policy? ❑ Self ❑ Parent ❑ Spouse Give name of Company _____

If covered under Parent's/Spouse's Insurance or if privately insured, please include the following information:

Policy #: _____ Group #: _____ Phone # of Insurance Company: _____

Parent's/Spouse's Name (Holder of Policy) _____ Social Security # _____

Employer's Name and Address _____

ASSIGNMENT OF BENEFITS:

PAYMENT WILL BE MADE TO THE PROVIDERS OF SERVICE (HOSPITAL, PHYSICIAN, AND OTHERS), UNLESS PAID RECEIPT OR STATEMENT ACCOMPANIES THE BILL AT THE TIME THE CLAIM IS SUBMITTED.

IMPORTANT: THIS FORM MUST BE COMPLETED AND RETURNED TO THE COMPANY WITHIN 90 DAYS FROM THE DATE OF TREATMENT ACCOMPANIED BY ALL BILLS INCURRED TO THAT DATE. PLEASE ATTACH ITEMIZED BILLS.

AUTHORIZATION: I hereby authorize Global Claims Administration, or its representative, to inspect or secure copies of case history records, laboratory reports, diagnosis, prognosis, x-rays, and any other data covering this and/or previous confinements and/or disabilities. By signing this form, you agree that all answers are honest and can be verified if any additional information is requested.
A photostatic copy of this authorization shall be deemed as effective and valid as the original.

SIGNATURE OF PARENT (If claimant is a minor) OR CLAIMANT: _____ **DATE:** _____

IMPORTANT NOTICE

Fraud Warning: Any person who, with the intent to defraud of knowingly facilitates a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, or conceals information for the purpose of misleading may be guilty of insurance fraud and subject to criminal and/or civil penalties.

Notice to Arizona Claimants: For your protection Arizona Law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Notice to California Claimants: For your protection California law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Notice to Colorado Claimants: It is unlawful to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement or aware payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Notice to Hawaii Claimants: For your protection Hawaii Law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment or both.

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

Notice to Kentucky Claimants: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such a person to criminal and civil penalties.

Notice to Oklahoma Claimants: Warning: Any person who knowingly, and with intent to injure, defraud or deceive any insurer makes any claim for the proceeds of an insurance policy containing any false, incomplete, or misleading information is guilty of a felony.

Notice to Pennsylvania Claimants: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such a person to criminal and civil penalties.

Notice to Texas Claimants: Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

HOW TO FILE A CLAIM

Please follow these instructions:

- Complete front of claim form, in full;
- A completed claim form must be submitted for each injury or sickness a student sustains;
- Sign Medical Authorization and Authorization to Pay Benefits on front of claim form;
- Mail to Administrator with itemized bills, showing diagnosis, and Explanation of Benefits from your primary insurance carrier for each bill (if applicable)

  Global Claims Administrators
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  Cincinnati, Ohio 45208 USA
  Tel: 800.513.2981 (Inside USA)
  Fax: 513.533.9416
  claims@globalunderwriters.com

All itemized bills must include:

1. Patient's Name;
2. Patient's Address;
3. Diagnosis;
4. Date of Service;
5. Description of Service (CPT Coding);
6. Medical Provider's Name, Address, Telephone Number, and Federal Tax ID Number

Keep copies of all claims forms, bills, and correspondence for your own records.
In order for benefits to be paid, claim forms must be filed within 90 days from the date of injury or sickness.