

Plan Administered by:



COMMERCIAL TRAVELERS
MUTUAL INSURANCE COMPANY
COMMERCIAL TRAVELERS BUILDING
UTICA, NEW YORK 13502

For Toll-free Policyholder Service
1-800-756-3702
Utica area 315-797-5200

Instructions

1. PART A — must be completed by the school.
2. PART B — must be completed by Parent or Guardian
3. Attach all itemized medical bills you have received to date. Later bills can be mailed to the insurance company separately. Please show name of school on all later bills.
4. Mail this report and bills within 90 days after the first treatment to:

**Special Risks Claims
Commercial Travelers Mutual
Insurance Company
70 Genesee Street
Utica, NY 13502**

Accident Claim Form

Please print or type

Part A: School Report

Instructions — school official completes this Part A, then gives the form to the student's parent or guardian to complete Part B on the reverse side. **Parent must provide name of school/school district, if not school related accident.**

If you have submitted an accident report to another insurance company, please attach a copy.

| | | | |
|---|---|---|-------|
| Name of School | | School District/Policyholder Schenectady City School District | |
| Phone No. () | | | |
| Address | | Policy No. SLA03 | |
| Street/Box# | City | State | Zip |
| Name of Student | | <input type="checkbox"/> Male <input type="checkbox"/> Female | Grade |
| Date of Accident / / | How Accident Occurred | | |
| Time of Accident <input type="checkbox"/> AM <input type="checkbox"/> PM | <input type="checkbox"/> Enroute to/from school | | |
| | <input type="checkbox"/> During school session | | |
| | <input type="checkbox"/> Practice or play of interscholastic sports Name of Sport _____ <input type="checkbox"/> JV <input type="checkbox"/> Varsity | | |
| | <input type="checkbox"/> Other _____ | | |
| How did accident happen? | | | |
| Details of Injury — including part of body injured: | | | |
| Name of Teacher or Coach Supervising the Activity | | | |
| 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 (in FL, a felony in the third degree), and in the state of New York, shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation. (This notice is not applicable in VA.) | | | |
| Signature of School Official/Title | | Date Signed | |

Plan Underwritten by: SECURITY MUTUAL LIFE INSURANCE COMPANY OF NEW YORK

Accident Claim Form

Please print or type

Part B: Statement of Parent or Guardian

| | | | |
|-------------------------|---------------------|----------------------|-------------------------|
| Name of Injured Student | Social Security No. | Date of Birth / / | Date of Accident / / |
|-------------------------|---------------------|----------------------|-------------------------|

| | |
|-----------------------------------|-------------------------|
| Name of Person Making this Report | Relationship to Student |
|-----------------------------------|-------------------------|

| | |
|---------------------------------------|-----------------------------------|
| Address Street/Box# City State Zip | Telephone Home () Work () |
|---------------------------------------|-----------------------------------|

| | | |
|--|------------|---------------------|
| Name of Student's Male Parent or Guardian | Occupation | Social Security No. |
| Address if different from student | | |

| |
|--|
| Employer's Name and Address Name Street/Box# City State Zip Phone # |
|--|

| | | |
|--|------------|---------------------|
| Name of Student's Female Parent or Guardian | Occupation | Social Security No. |
| Address if different from student | | |

| |
|--|
| Employer's Name and Address Name Street/Box# City State Zip Phone # |
|--|

Does either parent or guardian have Accident/Health Insurance which covers this student? Yes No
If yes, which person(s)

| | |
|--------------------------------|-------------------------|
| Name of Insurance Company(ies) | Name of Policyholder(s) |
|--------------------------------|-------------------------|

For Around-the-Clock Coverage only:
Date of injury (or) onset of sickness _____ When was physician first consulted? _____
Nature of injury (or) illness _____
If injury, how and where did accident occur? _____

Have you suffered same or similar condition in the past? Yes No If "Yes," and if you were treated for, it, please give name and address of the physician who treated you _____
Dates treated _____
Give name, address and telephone number of usual family physician _____
Phone _____

I hereby authorize any Insurance Company, Organization, Employer, Hospital, Physician, Surgeon or Pharmacy to release any information requested by the Security Mutual Life Insurance Company of New York or its representatives. A photostatic copy of this authorization shall be considered as effective and valid as the original.

I also authorize Security Mutual Life Insurance Company of New York or its representatives to pay all bills in connection with this claim directly to the doctor, hospital or any other persons rendering service, and such payment shall release Security Mutual Life Insurance Company of New York from liability as to amounts so paid.

I hereby certify that I have read the answers to all parts of this form and to the best of my knowledge and belief the information is complete and correct as given herein.

Name of Student _____

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 (in FL, a felony in the third degree), and in the state of New York, shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation. (This notice is not applicable in VA.)

| | |
|---------------------------------|-------------|
| Signature of Parent or Guardian | Date Signed |
|---------------------------------|-------------|