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PERSONAL ACCIDENT REIMBURSEMENT CLAIM FORM

☐ SCHOOL ☐ SPECIAL ACTIVITY ☐ DEATH ☐ DISMEMBERMENT

BASIC PLAN

TO BE COMPLETED BY SCHOOL OFFICER OR PERSON IN CHARGE OF THE SPECIAL ACTIVITY

Name of Insured	Age	Date of Birth	Grade	Social Security Number	Policy Number
					PASG-60-10402

Address	Name of Parent or Guardian	Telephone Number
University of the Virgin Islands Albert A. Sheen Campus RR 1 Box 10,000 Kingshill, USVI 00850-9781	Date insured enrolled for insurance _____	

How did accident/death occur? Explain:

Date of injury/death /dismemberment	Time ☐school ☐special activity started:	Time of injury/ death/dismemberment	Time student dismissed from ☐ school ☐ special activity	Was this activity under School supervision? Yes ☐ No ☐

Activity engaged in at time of injury/death/dismemberment? Yes ☐ No ☐

If accident did not occur at school/ special activity, did it occur on direct route between school/ special activity and home? Explain where and how:

Date: Hour:

☐ School Name ☐ Special Activity Name	☐ School Address ☐ Special Activity Sponsor Address
Telephone Number	E-mail: _____

SCHOOL OR SPECIAL ACTIVITY CERTIFICATION

I, _____ certify that the student _____
☐ School official's signature ☐ Person in charge of the special activity

paid the accident insurance premium for the school year of _____ or for the special activity _____.

Name of ☐ School Official ☐ Person in charge of the special activity: _____ Title: _____

Signature of ☐ School Official ☐ Person in charge of the special activity: _____ Date: _____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize and licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, Insurance Company, the Medical Information Bureau or other organizations, institutions or persons, that have any record or knowledge of the patient's health, to give to **Triple-S Vida** any such information. Also, I hereby authorize **Triple-S Vida** to release or obtain from any organization or person any information which may be necessary to determine benefits payable under this policy with **Triple-S Vida.**

Signature of Parent or Guardian: _____ Date: _____

INSTRUCTIONS

1. Please fill out all pertinent information concerning the accident.
2. Please be sure to sign the claim form.
3. Please verify that the policy number is included.
4. Please provide the ID required for this program if apply.
5. Please enclose receipts of payments.

ATTENDING PHYSICIAN'S STATEMENT

Patient's Name	Age	Sex ☐ M ☐ F	Nature of Injury/Death/Dismemberment

Diagnosis (Describe complications, if any)

If fracture or dislocation, state whether complete or incomplete	ICD Code No.
Was it confirmed by X-Rays? Yes ☐ No ☐	

When did accident/death happen? _____ Where did it occur? _____

How did it happen? _____

Nature of surgical procedure, if any (Give Details)

Indicate procedure code

Charge for this procedure	Date	Hospital	Office
$			

Name of Doctor: _____ Telephone: _____

Doctor's Signature: _____ License Number: _____

Address: _____ Social Security No. or ID No.: _____

_____

_____

AUTHORIZATION FOR PAYMENT

I hereby authorize payment directly to the hospital on the other side otherwise payable to me, but not exceed the policy limits for hospitalization benefits. I understand that I am financially responsible for any charges not covered by this authorization.

Signature of Parent or Guardian: _____ Date: _____