



STUDENT INJURY REPORT

2016-2017 PLAN YEAR
EFFECTIVE DATE: JULY 1, 2016

Policy Number: IHH000309

District Name: _____ School Name/Location #: _____

School Address: _____ School Phone #: _____

Student's Name _____
FIRST NAME MIDDLE INITIAL LAST NAME

Date of Birth _____ Sex: M F Parent's Day Time Phone _____

Parent's Address _____
STREET CITY STATE ZIP

ACCIDENT INFORMATION

Cause of Injury _____ Injury Date _____

Body Part Injured _____ Place of Injury _____

Nature of Injury — Details of What Happened _____

District/School Certification Signature Required:

I hereby certify the student is enrolled in school and the injury was sustained under adequate supervision while participating in a school sponsored activity.

Title of District/School Official Signature of District/School Official Date

..... District to Complete the Above Information

INSURANCE INFORMATION (TO BE COMPLETED BY PARENT OR GUARDIAN)

Does the parent/guardian have medical/health insurance? Yes No (Attach separate sheet if necessary.)

Insurance Company Name & Address _____

Policy Number _____ ID# _____

Parent / Guardian Certification Signature Required:

I authorize any physician/hospital that has attended my dependent child to disclose information thus acquired for the purpose of this claim payment. I hereby certify the above statements made by and certified by me to be true to the best of my knowledge.

Parent's Email Address: _____ Daytime Phone: _____

Signature of Parent / Guardian

Printed Name Parent / Guardian Date

To process your claim, you will need to submit the following pieces of information:

1. The completed and signed "Student Injury Report"
2. All Itemized Bills and Explanations of Benefits (EOBs) from Your Primary Insurance Company

Submit all documents via fax, email or US mail to:

A-G Administrators, Inc.
PO Box 979
Valley Forge, PA 19482
Phone: 610-933-0800
Fax: 610-933-4122
Email: claims@agadm.com

FRAUD WARNING: Any person who, knowingly and with intent to defraud, or helps commit a fraud against, any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits or may be committing a fraudulent insurance act, which is a crime and subjects such person to criminal and/or civil penalties. For residents of the following states, please see below: California, Colorado, District of Columbia, Florida, New York, Tennessee, Texas or Virginia.

California & Texas Residents: 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.