PLEASE RETURN THIS COMPLETED FORM AND RELATED BILLS TO:

Ascension Benefit & Insurance Solutions P.O. Box 25936 Overland Park, KS 66225 Or fax to 913.754.5604

Please Note: *All bills must first be submitted to any group hospital and/or medical plan to which you may be eligible. The primary Insurer's Explanation of Benefits indicating payments and/or denials must accompany this claim form.*

School Name:______________________________ Intercollegiate Sports

Part 1 **TO BE COMPLETED BY THE SUPERVISING OFFICIAL OF PARTICIPATING INSTITUTION**

Last Name of Student	First Name	Middle Initial	Year in School	Student ID Number
Sport	Was student involved in school sponsored event: ☐ Yes ☐ No		Date of Injury	Time of Injury
Description of Injury (What happened, how and where				
Sport designation: ☐ Intramurals ☐ Practice ☐ Game ☐ Other: (explain)				
I certify that all statements and answers on this form are true and complete, and that this claim satisfies all criteria set forth in our Accident Policy for proper consideration as a covered participant, covered activity and covered condition, to the best of my knowledge.				
Name and Title of Supervising Official	Signature		Date	

Part 2 **THIS SECTION TO BE COMPLETED BY THE STUDENT (PARENT OR GUARDIAN, IF MINOR)**

Please note that this section needs to be filled out completely in order to contact the student in the event that additional information is needed to process the claim. Failure to complete this section completely will delay the processing of the claim.

Local address of Student	Student phone No.	Date of Birth (MM/DD/YY)
Name and Address of Parent or Guardian (Street, State and Zip)	Parent/Guardian Phone No.	
Student email address	Parent /Guardian email address	
Have you previously had any treatment for this particular injury or treatment to this area of your body? If "YES", please describe the circumstances include how, when, and where:		Yes ☐ No ☐
Are you entitled to benefits under any other insurance policy covering this injury? If "YES", please attach copies of statements of benefits paid or denied and complete the following:		Yes ☐ No ☐
Name of Insurance Company	Phone number	Effective date
Name of Person Carrying Other Insurance Coverage:	Plan or Group Number	

Medical Information authorization/Assignment of Benefits/Authorization to Release Protected Health Information

I hereby authorize any licensed physician, hospital, clinic or other medically related facility, insurance company or other organization, institution or person that has any records, including any medical history of the above named person suffering loss, to furnish such information or copies of records to Aetna Student Health. A photographic copy of this authorization shall be as valid as the original. I can certify that the information given by me in support of this claim is valid and correct. Any person who knowingly and with intent to defraud any insurance company or other person files a 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. I also authorize Aetna Student Health to pay all bills in connection with the accident directly to the doctor, hospital or other rendering service. **I hereby authorize Aetna Life Insurance Company and its parents, subsidiaries, affiliates, employees, agents and subcontractors, to release my protected health information (PHI) to the educational institution identified in Part 1 of this claim form (the "Institution"), as well as to the agents, representatives, consultants, employees and contractors of the Institution (including, but not limited to, the supervising official listed in Part 1 of this claim form, the Institution's athletic program staff and any brokers of record acting as consultants or agents of the Institution). I understand that this authorization is voluntary. This authorization will be in effect for so long as I am a full or part time student enrolled at the Institution and for one year thereafter.**

SIGNED ______________________________ **DATE** ______________________

Injured Student (Parent or Guardian, if under 18)