P.O. Box 979
Valley Forge, PA 19482
610.933.0800
Fax: 610.935.2860
www.agadministrators.com

Student Accident Claim Form

Please complete and submit to A-G Administrators with itemized medical bills and primary insurance explanation of benefits. For questions, please contact A-G Administrators.

College/University _____

Student's Name _____
FIRST NAME MIDDLE INITIAL LAST NAME

Date of Birth _____ Sex: ❑ M ❑ F Cell Phone _____

Email Address _____

School Address _____
STREET CITY STATE ZIP

Home Address _____
STREET CITY STATE ZIP

ACCIDENT INFORMATION

Place of Accident _____ Accident Date _____

Circumstance: ❑ Game ❑ Practice ❑ Conditioning ❑ Other Type of Injury: ❑ Club Sport ❑ Intramural ❑ Intercollegiate ❑ Non-athletic

Body Part Injured _____ Sport if Athletic _____

Nature of Injury — Details of What Happened _____

_____

_____

INSURANCE INFORMATION

Does the claimant have primary insurance? ❑ Yes ❑ No *(Attach separate sheet if necessary.)*

Insurance Company Name & Address _____

Policy Number _____ ID# _____

AUTHORIZATION

AFFIDAVIT: I verify that the statement on other insurance is accurate and complete. I understand that the intentional furnishing of incorrect information via the U.S. Mail may be fraudulent and violate federal laws as well as state laws. I agree that if it is determined at a later date that there are other insurance benefits collectible on this claim I will reimburse A-G Administrators to the extent for which A-G Administrators would not have been liable.

AUTHORIZATION TO RELEASE INFORMATION: I authorize any Health Care Provider, Doctor, Medical Professional, Medical Facility, Insurance Company, Person or Organization to release any information regarding medical, dental, mental, alcohol or drug abuse history, treatment or benefits payable, including disability or employment related information concerning the patient, to A-G Administrators and its designees.

PAYMENT AUTHORIZATION: I authorize all current and future medical benefits, for services rendered and billed as a result of this claim, to be made payable to the physicians and providers indicated on the invoices.

_____ _____
STUDENT SIGNATURE *(Parent or guardian, if participant is a minor)* Date

_____ _____ _____
SCHOOL OFFICIAL SIGNATURE Title Date