CLAIM FORM 2008-2009

Coverage Verified

Mail To: P.I.A. Inc. P.O. Box 6040 Agoura Hills,CA 91376-6040 (800) 468-4343	**Notice:** Anyone who knowingly misrepresents or falsifies essential information requested by this form may upon conviction be subject to fine or imprisonment.	COMPLETE IN DETAIL TO INSURE PROMPT HANDLING

- PLEASE PRINT ALL INFORMATION -

MUST BE COMPLETED AND SIGNED BY STUDENT

(Check One)

University of California, San Diego

Please check appropriate box to indicate Policy number.

☐ Graduate, Pharmacy, and Professional
Policy No. AMH0068159

☐ Undergraduate (including Foreign Undergraduate)
Policy No. AMH0068169

National Union Fire Insurance Company of Pittsburgh, Pa.

Insured Student's Name (SHS – Please use patient label)

Student PID Number: ____________________________

Date Of Birth: ____________________________________

Present Address: ____ **City:** ______________________________

State: ___________________________ **Zip Code + 4:** ____________________ **Telephone Number:** (_____) ___________________

ARE YOU COVERED (as an insured or dependent) BY ANY HOSPITAL AND/OR MEDICAL PLAN OTHER THAN UCSD STUDENT INSURANCE? ☐ **YES** ☐ **NO**

If yes, name of plan ____

Date of accident or sickness	**Date of first treatment**	**Nature of sickness or injury**

Was sickness or injury related to an NCAA ICA Sport or Club Sport? Yes No
If yes, please explain:

PAYMENT WILL BE MADE TO THE PROVIDERS OF SERVICE, UNLESS A PAID RECEIPT IS ATTACHED AT TIME OF SUBMISSION.

To any medical care provider, medical care facility, Insurer, government sponsored health plan, or employer: I permit (while my claim is pending) the release of any medical information about me to the **Company** and its representatives. The Company's representatives include **Personal Insurance Administrators, Inc.**, reinsuring companies and other persons or groups performing business or legal services relating to my claim. This applies to information about the diagnosis, treatment, or prognosis of any illness or injury I now have or have had in the past. The Company will use this information if my claim is eligible. A copy of this authorization (one of which will be given to me by the Company upon my request) will be as valid as this one. I certify that the above information given by me in support of this claim is true and correct.

PATIENT'S SIGNATURE ____ **Date** ___________________