

CLAIM FORM 2009 - 2010

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. AMH0068150
- Undergraduate (including Foreign Undergraduate)
Policy No. AMH0068160

National Union Fire Insurance Company of Pittsburgh, Pa.

Insured Student's Name: (PLEASE PRINT CLEARLY or use SHS 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: NCAA ICA Sport or Club Sport Neither
Please indicate name of sport: _____

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** _____