



# MARKEL INSURANCE COMPANY

Please complete this form and submit to First Insurance Services - Attn: Sara Secor or to the address below:  
Please include email address for follow up:

**COMPLETE AND MAIL TO:**

PIONEER  
P. O. Box 9040  
West Springfield, MA 01090-9040  
(866) 653-2542

Claim procedures and online access to our  
claim form are available from our website at:

[www.collegeinsurance.com](http://www.collegeinsurance.com)

It is a crime to knowingly provide false, incomplete or misleading information  
to an insurance company for the purpose of defrauding the company.  
Penalties may include imprisonment, fines and denial of insurance benefits.

## CLAIM CANNOT BE PROCESSED WITHOUT THIS INFORMATION

COLLEGE (OR) UNIVERSITY <b>Wartburg College</b>		POLICY # <b>08200619</b>	SOC. SEC. # / ID #	
STUDENT'S NAME		MALE <input type="checkbox"/>	AGE	
IF CLAIM FOR DEPENDENT GIVE NAME AND RELATIONSHIP		FEMALE <input type="checkbox"/>	AG	
STUDENT / DEPENDENT FULL ADDRESS (WHILE AT SCHOOL)	STREET ADDRESS	CITY	STATE	ZIP
FULL ADDRESS (HOME)	STREET ADDRESS	CITY	STATE	ZIP
		TELEPHONE		

- (1) Date of injury (or) beginning of sickness \_\_\_\_\_ When physician first consulted? \_\_\_\_\_  
 Type of illness (or) injury \_\_\_\_\_  
 If pregnancy, please indicate your last menstrual period (LMP) date: \_\_\_\_\_  
 If injury, (a) How did accident occur? \_\_\_\_\_  
 (b) Where did accident occur? \_\_\_\_\_  
 (c) Were you practicing or playing **any** intercollegiate (between rival colleges) sport at the time of the accident?  Yes  No  
 Club Sport?  Yes  No Intramural Sport?  Yes  No If "Yes," name sport: \_\_\_\_\_
- (2) Were you treated by the Student Health Service?  Yes  No If "Yes," date: \_\_\_\_\_  
 Were you referred by the Student Health Service?  Yes  No If "Yes," date: \_\_\_\_\_  
 If "No," was the Student Health Service closed?  Yes  No
- (3) Hospital: (Give name, address and date of confinement) \_\_\_\_\_  
 \_\_\_\_\_ From / To \_\_\_\_\_
- (4) Give names, addresses and telephone numbers of all attending physicians \_\_\_\_\_  
 \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_
- (5) Give name, address and telephone number of usual family physician \_\_\_\_\_  
 \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_
- (6) Have you suffered same or similar condition in the past?  Yes  No If "Yes" and you were treated for it, please give name and  
 address of the physician who treated you: \_\_\_\_\_ Dates Treated: \_\_\_\_\_  
 If hospitalized at that time: Name of Hospital: \_\_\_\_\_  
 Address \_\_\_\_\_ Dates Confined: \_\_\_\_\_
- (7) **DO YOU HAVE OTHER INSURANCE WHICH COVERS THIS CONDITION, EITHER GROUP, INDIVIDUAL AUTOMOBILE, MEDICAL OR  
 LIABILITY?**  Yes  No **IF YES, HAVE THESE CHARGES BEEN SUBMITTED THROUGH YOUR OTHER CARRIER?**  Yes  No
- (8) Is condition due to injury or sickness arising out of your employment?  Yes  No

### AUTHORIZATION REGARDING PAYMENT OF BENEFITS

For services rendered or to be rendered I hereby authorize MARKEL INSURANCE COMPANY or their representatives to pay benefits in connection  
with this accident or illness direct to the doctor, hospital or other rendering service. If receipted bills are submitted, the benefits are to be paid to:  
**Claimant**

### AUTHORIZATION FOR RELEASE OF INFORMATION

I AUTHORIZE any physician, medical care provider, hospital, clinic, medical care facility, insurance company, government-sponsored health  
plan, or employer having information available as to diagnosis, treatment and prognosis with respect to any illness, injury, physical or mental  
condition, and/or treatment for me or my minor children now or in the past, to give to Markel Insurance Company (MIC) or its legal  
representative, any and all such information.

I UNDERSTAND the information obtained by the use of the Authorization will be used by MIC to determine eligibility for insurance and  
eligibility for benefits under any existing policy. Any information obtained will not be released by MIC to any person or organization EXCEPT as  
necessary in connection with the processing of this application, claim, or as may be otherwise lawfully required or as I may further authorize.

I KNOW that I may request to receive a copy of this Authorization.

I AGREE that a photographic copy of this Authorization shall be as valid as the original. I also AGREE this Authorization shall be valid for a  
period of two years from the date shown below. I may revoke this authorization at any time by written request to MIC.

I CERTIFY that the above information given by me in support of this claim is true and correct.

Claimant, Parent, or Authorized Representative's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If Authorized Representative, Relationship to Patient or Legal Designation: \_\_\_\_\_ Date: \_\_\_\_\_

To review our Privacy Policy, please go to [www.collegeinsurance.com](http://www.collegeinsurance.com)

# ATTENDING PHYSICIAN'S STATEMENT - HEALTH INSURANCE CLAIM ACCIDENT OR SICKNESS

PATIENT'S NAME AND ADDRESS \_\_\_\_\_

MALE   
FEMALE

AGE \_\_\_\_\_

(1a) Diagnosis and Concurrent Conditions (If fracture or dislocation, describe nature and location): \_\_\_\_\_

(b) If pregnancy, please indicate the patient's last menstrual period (LMP) date: \_\_\_\_\_

(c) Is condition due to injury or sickness arising out of patient's employment?  Yes  No If "Yes," explain: \_\_\_\_\_

(d) Describe any other disease or infirmity affecting present condition: \_\_\_\_\_

(2a) When did symptoms first appear or accident happen? Date \_\_\_\_\_, 20\_\_\_\_

(b) When did patient first consult you for this condition? Date \_\_\_\_\_, 20\_\_\_\_

(c) Has patient ever had same or similar condition?  Yes  No If "Yes," state when and describe: \_\_\_\_\_

(d) If patient referred by other doctor, give name and address of such doctor: Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

(3a) Nature of surgical or obstetrical procedure, if any (describe fully): (Please give CPT Procedure Code) \_\_\_\_\_

(b) Charge to patient for this procedure including postoperative care: Date performed \_\_\_\_\_, 20\_\_\_\_ \$ \_\_\_\_\_

(c) If performed in hospital, give name of hospital: \_\_\_\_\_  Inpatient  Outpatient

(4a) Give dates of other (non-surgical) treatment, if any: \_\_\_\_\_ (4c) CHARGE PER CALL

Office \_\_\_\_\_ \$ \_\_\_\_\_

(b) If patient hospitalized, give confinement dates, name and address of hospital: \_\_\_\_\_ Home \_\_\_\_\_ \$ \_\_\_\_\_

Hospital \_\_\_\_\_ \$ \_\_\_\_\_

Nursing Home \_\_\_\_\_ \$ \_\_\_\_\_

Total (non-surgical) charges \$ \_\_\_\_\_

(5) What other services, if any did you provide patient? (Itemize, giving dates and fees): \_\_\_\_\_

(6) Were registered private duty nurse (RN) services necessary? \_\_\_\_\_

(7) Is patient still under your care for this condition?  Yes  No If "No," give date your services terminated: \_\_\_\_\_, 20\_\_\_\_

(8) Did you file this claim with any other Insurance Company?  Yes  No If "Yes," indicate name and address of company: \_\_\_\_\_

**(ANSWER ALL QUESTIONS ABOVE, IN ADDITION TO THOSE BELOW, IF DENTISTRY.)**

1. State exactly which teeth were involved in the accident and indicate them on chart: \_\_\_\_\_

**DENTAL**

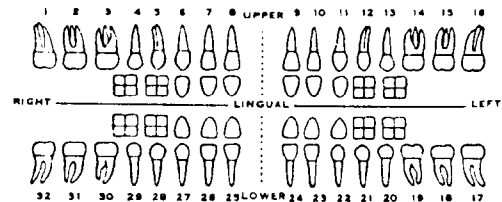
2. Describe exact nature of injury. \_\_\_\_\_

**INJURY**

3. Describe condition of injured teeth prior to accident:

Whole, Sound and Natural  Filled  Capped  Artificial

4. Comments \_\_\_\_\_



**REMARKS**

DATE \_\_\_\_\_

SIGNATURE (Attending Physician: Please Print) \_\_\_\_\_

DEGREE \_\_\_\_\_

I.R.S., I.D., or S.S. # \_\_\_\_\_

TELEPHONE \_\_\_\_\_

STREET ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_

STATE \_\_\_\_\_

ZIP CODE \_\_\_\_\_