



MARKEL INSURANCE COMPANY

COMPLETE AND MAIL TO:

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

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

www.collegeinsurance.com

CLAIM CANNOT BE PROCESSED WITHOUT THIS INFORMATION

COLLEGE (OR) UNIVERSITY				POLICY #		SOC. SEC. # / ID #	
STUDENT'S NAME				MALE <input type="checkbox"/>		AGE	
				FEMALE <input type="checkbox"/>			
IF CLAIM FOR DEPENDENT GIVE NAME AND RELATIONSHIP				MALE <input type="checkbox"/>		AGE	
				FEMALE <input type="checkbox"/>			
STUDENT / DEPENDENT FULL ADDRESS (WHILE AT SCHOOL)	STREET ADDRESS	CITY	STATE	ZIP	TELEPHONE		
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: _____ 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 received bills are submitted, the benefits are to be paid to: _____

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

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

PATIENT'S NAME AND ADDRESS	MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>	AGE
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(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 _____	\$ _____
Home _____	\$ _____
Hospital _____	\$ _____
Nursing Home _____	\$ _____
Total (non-surgical) charges _____	\$ _____

(b) If patient hospitalized, give confinement dates, name and address of hospital: _____

(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:

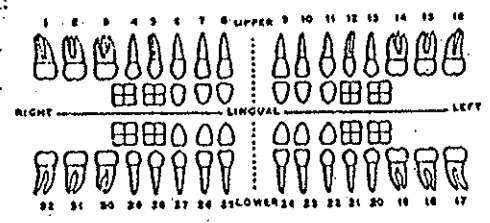
DENTAL

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. #	CITY	STATE
STREET ADDRESS	STATE	ZIP CODE
TELEPHONE		