

National Union Fire Insurance Co of Pittsburgh, Pa

Mail claims to:
 Fringe Benefit Coordinators Inc.
 P.O. Box 5249
 Gainesville, FL 32627-5249
 Telephone (800) 654-1452 Fax Number (352) 372-9805

PROOF OF LOSS

NAME OF GROUP: Florida College System Risk Management Consortium
POLICY NUMBER: SRG0009125112

SPECIAL RISK ACCIDENT CLAIM FORM

INSTRUCTIONS:

- 1.) You must have **SECTION A** fully completed by a designated official of the Policyholder.
- 2.) **SECTION B** is to be completed, signed and dated by the student or parent/guardian of student, if student is a minor.
- 3.) Attach itemized bills for all medical expenses being claimed including the claimant's name, condition being treated (diagnosis), description of services, date of service(s) and the charge made for each service. **PLEASE MAIL OR FAX COMPLETED FORM AND BILLS TO ABOVE ADDRESS.**

EXCESS PLAN - Eligible covered expenses will be determined after benefits have been paid by other valid and collectible insurance. You must submit your claim to your other insurance company first. When you receive their Benefit Statement (EOB) send it to us along with the itemized bills. If you have no other insurance coverage, benefits will be paid on a Primary basis up to the policy maximum. Benefits for eligible expenses will be paid per policy terms.

The furnishing of this form, or its acceptance by the Company, must not be construed as an admission of any liability on the Company, nor a waiver of any of the conditions of the insurance contract.

SECTION A - MUST BE COMPLETED AND SIGNED BY A DESIGNATED REPRESENTATIVE OF THE POLICYHOLDER

COLLEGE NAME:

STUDENT'S FULL NAME (PLEASE PRINT CLEARLY OR TYPE)	SOCIAL SECURITY NUMBER	DATE OF BIRTH	DAYTIME TELEPHONE NUMBER OR EMAIL ADDRESS ()
--	------------------------	---------------	--

DATE COVERAGE BEGAN 8/26/10	DATE AND TIME OF ACCIDENT	NAME OF INSTRUCTOR
DATE COVERAGE WILL END/HAS ENDED 8/26/11		

NATURE OF INJURY (DESCRIBE FULLY, INCLUDING WHICH PART OF BODY WAS INJURED.)	DESCRIBE HOW AND WHERE ACCIDENT OCCURRED
--	--

PROGRAM NAME	DID ACCIDENT OCCUR:	<input type="checkbox"/> YES	<input type="checkbox"/> NO
INDICATE THE CLASS (IF APPLICABLE)	A. WHILE CLAIMANT WAS SUPERVISED	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	B. DURING SPONSORED ACTIVITY	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	C. DURING PROGRAMMED HOURS	<input type="checkbox"/> YES	<input type="checkbox"/> NO
	D. WHILE TRAVELING TO OR FROM REGULARLY SCHEDULED ACTIVITY IN A SUPERVISED GROUP	<input type="checkbox"/> YES	<input type="checkbox"/> NO

COLLEGE REPRESENTATIVE (PLEASE PRINT OR TYPE)	TITLE	DAYTIME TELEPHONE NUMBER OR EMAIL ADDRESS ()
---	-------	--

SIGNATURE OF COLLEGE REPRESENTATIVE	DATE
-------------------------------------	------

SECTION B - MUST BE COMPLETED BY THE STUDENT OR PARENT/GUARDIAN IF STUDENT IS A MINOR

IS STUDENT COVERED UNDER ANY OTHER HEALTH INSURANCE POLICY?	YES	NO
---	-----	----

IF YES, NAME, ADDRESS, AND PHONE # OF OTHER INSURANCE COMPANIES UNDER WHICH STUDENT IS INSURED:	POLICY #/ACCOUNT #
---	--------------------

IF STUDENT IS A MINOR, NAME OF STUDENT'S GUARDIAN/RELATIONSHIP TO CLAIMANT

ADDRESS OF STUDENT (IF STUDENT IS A MINOR, NAME AND ADDRESS OF STUDENT'S GUARDIAN)	GUARDIAN'S EMAIL ADDRESS
--	--------------------------

NAME/ADDRESS/TELEPHONE # OF EMPLOYER (IF STUDENT IS A MINOR, GUARDIAN'S EMPLOYER)	EMPLOYER'S DAYTIME TELEPHONE # ()
---	---------------------------------------

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

AUTHORIZATION and ASSIGNMENT OF BENEFITS

I, the undersigned authorize any hospital or other medical-care institution, physician or other medical professional, pharmacy, insurance support organization, governmental agency, group policyholder, insurance company, association, employer or benefit plan administrator to furnish to the Insurance Company named above or its representatives, any and all information with respect to any injury or sickness suffered by, the medical history of, or any consultation, prescription or treatment provided to, the person whose death, injury, sickness or loss is the basis of claim and copies of all of that person's hospital or medical records, including information relating to mental illness and use of drugs and alcohol, to determine eligibility for benefit payments under the Policy Number identified above. I authorize the group policyholder, employer or benefit plan administrator to provide the Insurance Company named above with financial and employment-related information. I understand that this authorization is valid for the term of coverage of the Policy identified above and that a copy of this authorization shall be considered as valid as the original. I understand that I or my authorized representative may request a copy of this authorization.

I authorize payment of medical benefits to the physician or supplier for service performed. YES NO

CALIFORNIA: For your protection, California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

For residents of New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the subject motor vehicle or stated claim for each such violation.

For residents of Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

For claimants not residing in California, New York, or Pennsylvania: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

SIGNATURE OF STUDENT OR PARENT/ GUARDIAN

DATE