

SCHOOL ACTIVITIES

Florida State College at Jacksonville Notification of Injury

Mail to: Florida State College at Jacksonville, Risk Management Department, 501 West State Street, Jacksonville, FL 32202

- A. Excess Coverage—Eligible covered expenses will be paid only if they are in excess of other valid and collectible insurance. You must submit the claim to your primary insurance before we can compute payment.
- B. The claim must be submitted within 90 days from the date of the accident. Physician's service must begin within 60 days.
- C. All bills submitted must be ITEMIZED for services and show dates for each service or treatment.
- D. Forward additional bills to the address above. No additional claim forms are needed, please note the school name and a social security number of the student on any additional bills.

"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 fact material thereto, commits a fraudulent insurance act, which is a crime."

Part A		TO BE COMPLETED BY STUDENT		
NAME OF STUDENT	(Last Name)	(First Name)	(Middle Initial)	PATIENT'S DATE OF BIRTH
				SEX <input type="checkbox"/> M <input type="checkbox"/> F
PATIENT'S SOCIAL SECURITY NUMBER			DATE & TIME OF ACCIDENT OR BEGINNING OF ILLNESS	
NATURE OF INJURY			ACCIDENT DUE TO EMPLOYMENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	
FOR ACCIDENTAL INJURIES, PLEASE COMPLETE THE FOLLOWING				
A. DESCRIBE ACTIVITY ENGAGED IN AT TIME OF ACCIDENT _____ _____				
B. PLACE OF ACCIDENT (BE SPECIFIC) _____				
C. DESCRIBE HOW ACCIDENT HAPPENED _____				
D. IF CLAIM IS FOR A SPORTS INJURY, WAS IT AN INTRAMURAL SPORT? <input type="checkbox"/> YES <input type="checkbox"/> NO OR INTERSCHOLASTIC SPORT? <input type="checkbox"/> YES <input type="checkbox"/> NO				
Is insured covered under any other health/accident insurance or prepayment plan? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, please list names and address and identifying information, i.e. policy and Social Security number. Please submit a copy of an Explanation of Benefits from your other insurance carrier or prepayment plan. _____ _____ _____				
AUTHORIZATION TO RELEASE INFORMATION				
I authorize any Health Care Provider, Insurance Company, Employer, Person or Organization to release any information regarding medical, dental, mental, alcohol or drug abuse history, treatment or benefits payable, including disability or employment related information, to Florida State College at Jacksonville, Risk Management Department, to the Plan Administrator, or their employees and authorized agents for the purpose of validating and determining benefits payable. This data may be extracted for use in audit or statistical purposes. I understand that I or my authorized representative will receive a copy of this authorization upon request. This authorization or a photostatic copy of the original shall be valid for the duration of the claim.				
NAME OF INSURED	SIGNATURE OF INSURED (PARENT OR GUARDIAN IN THE EVENT OF MINORITY OR INCAPACITY)			DATE SIGNED
PAYMENT AUTHORIZATION				
I authorize payment directly to those physicians or providers described below, and/or as indicated on the enclosed bills, of medical benefits otherwise payable to me.				
SIGNATURE OF INJURED (PARENT OR GUARDIAN IN THE EVENT OF MINORITY OR INCAPACITY)				DATE SIGNED

Part B TO BE COMPLETED BY POLICYHOLDER / ADMINISTRATOR COLLEGE OFFICIAL			
EFFECTIVE DATE OF COVERAGE	COVERAGE TERMINATION DATE, IF APPLICABLE	POLICY NUMBER	NAME OF COLLEGE OR UNIVERSITY FLORIDA STATE COLLEGE
ADDRESS OF SCHOOL (Street) 501 West State State Street	(City) Jacksonville,	(State) FL	(Zip Code) 32202
			TELEPHONE NUMBER (904) 632-3127
IF ACCIDENT OCCURRED DURING AN ACTIVITY SPONSORED OR SUPERVISED BY YOUR ORGANIZATION, DESCRIBE ACTIVITY, HOW ACCIDENT OCCURRED, AND SPECIFY DATE OF OCCURRENCE.			
REMARKS:			
I CERTIFY THAT THE FOREGOING INFORMATION IS TRUE AND CORRECT.			
AUTHORIZED SIGNATURE	TITLE	DATE	