Upon Completion, mail this form to:

Karen Mulder
Billing & Insurance Coordinator
Wheaton College
501 College Avenue
Wheaton, IL 60187

❖ *Student Insurance Claim Form* ❖

School Name: ______________________

Student's Name:	Social Security Number:	Date of Birth

Student's Address:	City	State	Zip	Phone

Is this claim for your dependent?: ❑ Spouse ❑ Child

Dependent's Name:	Social Security Number:	Date of Birth

Do you, your dependents, or your parents have any other insurance or medical plan that covers this condition? ❑ Yes ❑ No

If Yes, Please enter the name of the insurance company ______________________

1. For an **illness:**

Please describe symptoms: ______________________

Date of Illness: / /

Date you first consulted a physician for this illness: / /

Have you ever sought treatment for this illness in the past? ❑ Yes ❑ No

If Yes, please describe past treatments and dates: ______________________

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1. For an **injury:**

Date of Injury: / /

Please describe where and how injury occurred ______________________

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Was the injury a result of an auto accident? ❑ Yes ❑ No

Were you injured while working on a job? ❑ Yes ❑ No

Were you injured during the practice or play of an intercollegiate sport? ❑ Yes ❑ No

If Yes, signature of Athletic Director______________________

Have you ever sought treatment for this injury in the past? ❑ Yes ❑ No

If Yes, please describe past treatments and dates: ______________________

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Were you treated by Student Health Services and referred for this condition? ❑ Yes ❑ No

Seen by: ______________________

If not referred, why: ❑ Away from school ❑ Winter/Spring/Summer Break ❑ Other (attach explanation)

I authorize any physician, hospital, company, employer, or organization to release the medical history, treatments or benefits payable for this claim to Consolidated Health Plans or its payor for which it is an authorized plan administrator. A photostatic copy of this form shall be just as valid as the original. I authorize Consolidated Health Plans or its representatives to pay all bills in conjunction with this claim directly to the physician, hospital or other health care provider rendering service.

I certify that I have read all answers to this form, and to the best of my knowledge the information I have given is complete and true. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material hereto, commits a fraudulent insurance act, which is a crime and shall be subject to a civil penalty (not to exceed five thousand dollars in New York) and the stated value of the claim for each violation.

______________________ Signature of claimant

______________________ Date

GENCHP