HOW TO COMPLETE A CLAIM FORM

ALL INFORMATION SHOULD BE COMPLETED BY THE STUDENT

Relation

Relation Insurance Services
P.O. Box 25936
Overland Park, KS 66225

CLAIM FORM

PLEASE COMPLETE IN FULL TO ENSURE PROPER PROCESSING

SCHOOL/ORGANIZATION		POLICY NUMBER (CAN BE FOUND ON ID CARD)	
INSURED'S LAST NAME		INSURED'S FIRST NAME	MI
INSURED'S U.S. MAILING ADDRESS—NUMBER AND STREET NAME (OR P.O. BOX #), CITY, STATE, ZIP			
INSURED'S DATE OF BIRTH (MM/DD/YY)	☐ FEMALE ☐ MALE	INSURED'S SCHOOL ID NUMBER	INSURED'S PHONE NUMBER

If claimant is a Dependent currently insured under this plan, complete information below (in addition to the above).

CLAIMANT'S LAST NAME		CLAIMANT'S FIRST NAME	MI
CLAIMANT'S U.S. MAILING ADDRESS —NUMBER AND STREET NAME (OR P.O. BOX #), CITY, STATE, ZIP			
CLAIMANT'S DATE OF BIRTH (MM/DD/YY)	☐ FEMALE ☐ MALE	CLAIMANT'S PHONE NUMBER	

SECTION 1 – INJURY OR SICKNESS INFORMATION

1. Is this claim pertaining to a sickness/medical condition or an injury? ☐ Sickness ☐ Injury If injury, please fill out the information below.
   If claim is for a sickness/medical condition, skip to Section 2.
   a) How and where injury occurred; and brief description of injury:

   _____
   _____
   _____
   _____

   Date of Injury: _____

   b) Did injury occur at work? ☐ No ☐ Yes If yes, name of employer: _____

   c) Did injury occur during practice or play of school-sponsored sports? ☐ No ☐ Yes If yes, please complete information about the sport below.
   Name of Sport: _____ ☐ Intercollegiate ☐ Intramural/Club
   If intercollegiate, report to trainer and get signature. Signature of Athletic Trainer: _____

SECTION 2 – REFERRAL INFORMATION

2. Did you visit the campus health center for treatment of this injury or sickness? ☐ No ☐ Yes ☐ N/A (skip to Section 3)
   If yes, signature and title of health center official: _____
3. Did you receive a referral to an outside doctor by the campus health center, or from one provider to see different provider? ☐ No ☐ Yes
   If yes, please send a copy of the referral with this form.

SECTION 3 – OTHER INSURANCE INFORMATION

4. Do you have *other* insurance which covers your condition such as a group or individual health plan, government health plan, or automotive insurance plan (if auto accident)? ☐ No ☐ Yes
   If yes, who is the Policyholder? ☐ Self ☐ Parent ☐ Spouse Name of Insurance Carrier: _____
   Member No.: _____ Group No.: _____ Insurance Co. Phone No.: _____
   Primary Insured's Name (Parent/Spouse/Self): _____

SECTION 4 –PRIOR INSURANCE COVERAGE

5. Did you have *prior* insurance which covered your condition such as a group or individual health plan, government health plan, or automotive insurance plan (if auto accident)? ☐ No ☐ Yes
   If yes, who is the Policyholder? ☐ Self ☐ Parent ☐ Spouse Name of Insurance Carrier: _____
   Coverage Effective Date: _____ Coverage Term Date: _____
   Member No.: _____ Group No.: _____ Insurance Co. Phone No.: _____
   Primary Insured's Name (Parent/Spouse/Self): _____

TBOR / 1018

Enter Student Information
This section asks for basic identifying information, such as name, address, and student ID. International students should use their current U.S. address, not their permanent home address abroad.

If an insured dependent is filing the claim, fill out the "claimant" section with dependent's information.

SECTION 1
Injury or Sickness Information
This section asks for all the details of the sickness or injury. If reporting an injury, it's important for the claim administrator to understand if injury happened while on the job, playing sports, or riding in an automobile.

SECTION 2
Referral Information
If a health center referral is required, or if the deductible is waived with a health center referral, this section must be completed and the referral must be attached.

SECTION 3
Other Insurance Information
If the student has coverage under another plan, the school plan will pay secondary, in which case the student must submit a claim to the other insurance first, then to Relation second for covered amounts not paid by the other plan.

SECTION 4
Prior Insurance Coverage
If the student had insurance prior to the current plan, provide the prior insurance information.

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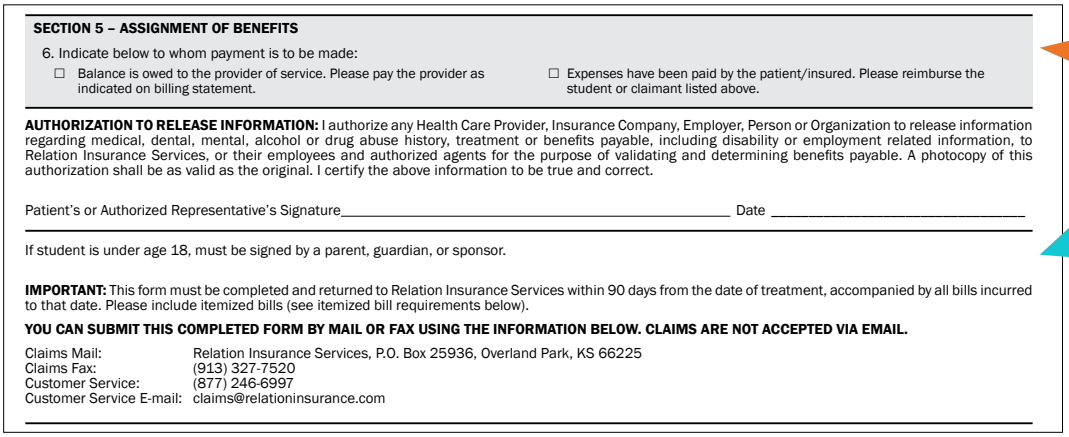
(CONTINUED)



SECTION 5 – ASSIGNMENT OF BENEFITS

6. Indicate below to whom payment is to be made:

☐ Balance is owed to the provider of service. Please pay the provider as indicated on billing statement.

☐ Expenses have been paid by the patient/insured. Please reimburse the student or claimant listed above.

AUTHORIZATION TO RELEASE INFORMATION: I authorize any Health Care Provider, Insurance Company, Employer, Person or Organization to release information regarding medical, dental, mental, alcohol or drug abuse history, treatment or benefits payable, including disability or employment related information, to Relation Insurance Services, or their employees and authorized agents for the purpose of validating and determining benefits payable. A photocopy of this authorization shall be as valid as the original. I certify the above information to be true and correct.

Patient's or Authorized Representative's Signature_____ Date _____

If student is under age 18, must be signed by a parent, guardian, or sponsor.

IMPORTANT: This form must be completed and returned to Relation Insurance Services within 90 days from the date of treatment, accompanied by all bills incurred to that date. Please include itemized bills (see itemized bill requirements below).

YOU CAN SUBMIT THIS COMPLETED FORM BY MAIL OR FAX USING THE INFORMATION BELOW. CLAIMS ARE NOT ACCEPTED VIA EMAIL.

Claims Mail: Relation Insurance Services, P.O. Box 25936, Overland Park, KS 66225
Claims Fax: (913) 327-7520
Customer Service: (877) 246-6997
Customer Service E-mail: claims@relationinsurance.com

SECTION 5
Assignment of Benefits
This section instructs the claims administrator to whom payments should be made.

SECTION 6
Authorization to Release Information
This section is used as a release of personal information so that medical providers and the claims administrator can share pertinent medical information.

7. **IMPORTANT**
   This form must be completed and returned to the company within 90 days from the date of treatment, accompanied by all bills incurred to that date. Please include itemized bills.

8. **ATTACH STUDENT HEALTH CENTER REFERRAL**
   If a health center referral is required, or if the deductible is waived with a health center referral, make sure to include the referral with your claim.

9. **ATTACH ITEMIZED BILLS**
   Make sure to send all itemized bills, as well as prescription drug receipts, if applicable, with claim form. It's a good idea to write your name and student number on all bills you attach.

10. **SEND THE COMPLETED FORM EITHER BY MAIL OR FAX.**