

STATEMENT OF OTHER INSURANCE - MUST BE COMPLETED

1. Father's Name:	2. Name and Address of His Employer:	
3. Mother's Name:	4. Name and Address of Her Employer:	
5. Spouse's Name:	6. Name and Address of Spouse's Employer:	
7. Name and Address of Claimant's Employer:		8. <input type="checkbox"/> Yes I do have other personal or group medical insurance.
Names of Other Insurance Companies		Address
9. <input type="checkbox"/> No, I am not covered under other personal group medical insurance of any sort. (CHECK ALL THAT APPLY) <input type="checkbox"/> Due to my age, I am no longer eligible for coverage under my parent's plan. <input type="checkbox"/> My parents are self-employed or unemployed. <input type="checkbox"/> My parents are employed but do not have health insurance. (You must submit a statement from employer verifying that there is no health insurance in force.) <input type="checkbox"/> I am an international student and my parent's insurance does not cover me in the U.S. <input type="checkbox"/> I and/or my spouse is not employed. <input type="checkbox"/> I and/or my spouse is employed but do not have any other health insurance. (You must submit a statement from employer verifying that there is no health insurance in force) <input type="checkbox"/> Other (please provide details below) _____ _____ _____		

INSTRUCTIONS

To avoid processing delays, please follow all instructions:

1. The student (not the Doctor or Hospital) must submit a fully completed claim form within 90 days of an accident or sickness. Only one form is needed for each accident/sickness.
2. Subsequent bills must be submitted within 90 days of the date of service and should clearly indicate patient name, name of College or Policy Number, and Diagnosis. All bills must be itemized as claims cannot be processed from balance due statements.
3. Intercollegiate Sports Accident claims must be signed by an authorized athletic official.
4. If a Health Center Referral is required, the Health Center questions must be fully completed.
5. The Statement of Other Insurance section above **MUST** be completed on policies where this plan is secondary to other insurance. If employed with no insurance, a statement of verification from the employer must be submitted on their letterhead.
6. Please keep a copy of this claim form, all bills and primary insurance Explanations of Benefits for your records.

PLAN ADMINISTRATION AND CLAIM SERVICE BY:



P.O. BOX 727, SHORT HILLS, N.J. 07078-0727 • TELEPHONE (866) 267-0092