***Plan Administered by:***

**COMMERCIAL TRAVELERS MUTUAL INSURANCE COMPANY**
**COMMERCIAL TRAVELERS BUILDING**
**UTICA, NEW YORK 13502**

For Toll-free Policyholder Service 1-800-756-3702 • Utica area 315-797-5200

*Please check the correct Underwriting Company:*

☐ COMMERCIAL TRAVELERS MUTUAL INSURANCE COMPANY
☐ NIAGARA LIFE AND HEALTH

**Notice:** When we are the secondary plan, we do not pay until after the primary plan has paid its benefits if any. We will review Usual & Customary charges of each plan and allow the highest. Any amount paid by your primary plan for an eligible expense under our plan may satisfy all or a portion of our deductible.

**CLICK HERE TO RESET FORM**

EmblemHealth GHI network access
www.emblemhealth.com
1-866-861-7153

**Instructions**

1. PART A — must be completed by the school.
2. PART B — must be completed by Parent or Guardian
3. Attach all itemized medical bills you have received to date. Later bills can be mailed to the claims administrator separately. Please show name of school on all later bills.
4. Mail this report and bills within 90 days after the first treatment to:

Special Risks Claims
Commercial Travelers Mutual Insurance Company
70 Genesee Street • Utica, NY 13502

# Accident Claim Form

**Please print or type**

## Part A: School Report

Instructions — school official completes this Part A, then gives the form to the student's parent or guardian to complete Part B on the reverse side. **Parent must provide name of school/school district, if not school related accident.**

**If** you have submitted an accident report to another insurance company, please attach a copy.

Name of School

Phone No.

School District/Policyholder

Address

Street/Box# City State Zip

Policy No.

Name of Student

☐ Male ☐ Female

Grade

Date of Accident

Time of Accident

☐ AM
☐ PM

How Accident Occurred

☐ Enroute to/from school
☐ During school session
☐ Practice or play of interscholastic sports
Name of Sport _____ ☐ JV ☐ Varsity
☐ Other _____

How did accident happen?

Details of Injury — including part of body injured:

Name of Teacher or Coach Supervising the Activity

Any person who knowingly and with intent to defraud any insurance company or other person files an application for health insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, any 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 $5,000.00 and the stated value of the claim for each such violation.

Signature of School Official/Title

Date Signed

—Reverse side must be completed by parent or guardian—

# Accident Claim Form
**Please print or type**

## Part B: Statement of Parent or Guardian

| Name of Injured Student | Social Security No. | Date of Birth / / | Date of Accident / / |
|---|---|---|---|

Name of Person Making this Report | Relationship to Student

Address
Street/Box# City State Zip

Telephone
Home ( )
Work ( )

| Name of Student's **Male Parent** or Guardian<br>Address if different from student | Occupation | Social Security No. |
|---|---|---|

Employer's Name and Address

Name Street/Box# City State Zip Phone #

| Name of Student's **Female Parent** or Guardian<br>Address if different from student | Occupation | Social Security No. |
|---|---|---|

Employer's Name and Address

Name Street/Box# City State Zip Phone #

Does either parent or guardian have Accident/Health Insurance which covers this student? ❒ Yes ❒ No
If yes, which person(s)

Name of Insurance Company(ies) | Name of Policyholder(s)

**For Around-the-Clock Coverage only:**

Date of injury (or) onset of sickness _____ When was physician first consulted? _____

Nature of injury (or) illness _____

If injury, how and where did accident occur? _____

Have you suffered same or similar condition in the past? ❒ Yes ❒ No If "Yes,' and if you were treated for, it, please give name and address of the physician who treated you _____

Dates treated _____

Give name, address and telephone number of usual family physician _____

_____ Phone _____

I hereby authorize any physician, hospital, company, employer, or organization to release any information regarding the medical history, treatment, or benefits payable for this claim, to the Insurance Company checked on the reverse or its authorized benefit plan administrator. A photostatic copy of this authorization shall be as valid as the original.

I also authorize the Insurance Company checked on the reverse or their representatives to pay all bills in connection with this claim directly to the doctor, hospital or any other persons rendering service, and such payment shall release the Insurance Company from liability as to amounts so paid.

I hereby certify that I have read the answers to all parts of this form and to the best of my knowledge and belief the information is complete and correct as given herein.

Name of Student _____

Any person who knowingly and with intent to defraud any insurance company or other person files an application for health insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, any 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 $5,000.00 and the stated value of the claim for each such violation.

| Signature of Parent or Guardian | Date Signed |
|---|---|