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

Instructions

- PART A <u>must</u> be completed by the school.
 PART B <u>must</u> be completed by Parent or Guardian
 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

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.

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		School District/Policyholder			
Phone No. ()					
Address					
Street/Box# City	State Zip	Policy No.			
Name of Student		☐ Male ☐ Female	Grade		
Date of Accident / /	How Accident Occurred Enroute to/from school During school session				
Time of Accident AM PM	PracticeName of	☐ Practice or play of interscholastic sports Name of Sport ☐ JV ☐ Varsity			
How did accident happen?					
Details of Injury — including part of body injured:					
Name of Teacher or Coach Supervising the Activity					
FOR RESIDENTS OF ALL STATES OTHER THAN T intent to defraud, injure or deceive any insurance common containing any false or incomplete information commit such person to confinement in prison, fines and denial	npany, files or ca ts a fraudulent ir	uses to be filed, a claim for	payment of a loss,		
Signature of School Official/Title		Date Signed	Date Signed		

—Reverse side must be completed by parent or guardian—

Form 2013W

Accident Claim Form Please print or type

Part B: Statement of Parent or Guardian

Name of Injured Student	Name of Injured Student Social Security		ty No.	Date of Birth		Date of Accident	
Name of Person Making this Report				Relationship to Student			
Address				Telephone			
Other at /Day //	Oit.	04-4-	7:	Home () ——		
Street/Box#	City	State	Zip	Work (Conint Conveits No	
Name of Student's Male	Parent or Guardian			Occupation		Social Security No.	
Address if different from	student						
Employer's Name and A	ddress						
Name S	Street/Box#	City		State	Zip	Phone #	
Name of Student's Fema	le Parent or Guardi	an		Occupation		Social Security No.	
Address if different from	student						
Employer's Name and A							
Name S	Street/Box#	City		State	Zip	Phone #	
Does either parent or gual If yes, which person(s)	ardian have Acciden	t/Health Insuranc	e which co	overs this stude	ent? [J Yes □ No	
Name of Insurance Com	Name of Insurance Company(ies) Name			of Policyholder(s)			
For Around-the-Clock (Coverage only:						
			When \	was physician f	irst consu	ulted?	
Nature of injury (or) illnes	ss						
If injury, how and where	did accident occur?						
Have you suffered same	or similar condition	in the past?	es □ No	If "Yes,' and	if you we	ere treated for, it, please give	
name and address of the	physician who treat	ted you					
Dates treated							
Give name, address and telephone number of usual family physician							
Phone							
I hereby authorize any plical history, treatment, or benefit plan administrato	hysician, hospital, co benefits payable for r. A photostatic copy	ompany, employer this claim, to the of this authorization	r, or organ e Insuranc ion shall b	ization to relea ce Company ch pe as valid as th	se any in ecked or he origina	oformation regarding the med- the reverse or its authorized	
I also authorize the Insur claim directly to the doct Company from liability as	tor, hospital or any o	other persons rer	se or their idering se	representative rvice, and such	s to pay a	all bills in connection with this at shall release the Insurance	
I hereby certify that I have tion is complete and corr		to all parts of this	form and	to the best of r	my knowl	ledge and belief the informa-	
Name of Student							
FOR RECIDENTS OF A	LL CTATES OFFICE	THAN THOSE :	ICTED C	N DAGE 2 A		uda a la constitución de la 190	
FOR RESIDENTS OF All intent to defraud, injure of containing any false or in such person to confinem	or deceive any insura acomplete informatio	ance company, filen n commits a frau	es or caus dulent inst	ses to be filed, a	a claim fo	or payment of a loss,	
Signature of Parent or G	uardian			Date Signed			

- AK, CT, DE, HI, IA, ID, IL, IN, MI, MN, MO, MT, MS, NC, ND, NV, SC, SD, UT, WI & WY: Any person who knowingly and with intent to defraud an insurer submits a written application or claim containing any materially false or misleading information is guilty of insurance fraud.
- AL, AR, DC, LA, MA, and RI: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
- AZ: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.
- CA: For your protection California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.
- CO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the department of regulatory agencies."
- FL: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.
- GA, NE, KS, OR, TX, VT: Any person who knowingly and with intent to defraud an insurer submits a written application or claim containing any materially false or misleading information may be quilty of insurance fraud.
- **KY**: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.
- ME: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.
- **MD**: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
- **NH**: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud.
- NJ: Any person who includes any false or misleading information on an application or statement of claim for an insurance policy is subject to criminal and civil penalties.
- NM: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.
- **NY:** 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.
- **OH:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.
- PA: 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 thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.
- **OK**: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.
- **TN**: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.
- VA, WA: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines or a denial of insurance benefits.
- **WV**: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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