



School Insurance Specialists

# GENERAL LIABILITY INCIDENT/ACCIDENT REPORT

Please use separate form for additional injuries

Member Name: \_\_\_\_\_ Policy #: \_\_\_\_\_

Date of Incident/Accident: \_\_\_\_\_ Time: \_\_\_\_\_  a.m.  p.m.

Name of Injured: \_\_\_\_\_

Is Injured: Student  Employee  Visitor  Volunteer

Date of Birth: \_\_\_\_\_ Parent Name: \_\_\_\_\_

Address of Injured/Parent: \_\_\_\_\_

Telephone # of Injured/Parent: Home: (\_\_\_\_) \_\_\_\_\_ Work: (\_\_\_\_) \_\_\_\_\_

Location of Accident: School Bldg.  School Grounds  School Bus  To/From School

Other  Describe: \_\_\_\_\_

Place of Accident: Classroom  Gym  Shop  Hallway/Stairway

Playground  Parking Lot  Sporting Event/Practice

Other  Describe: \_\_\_\_\_

Describe Incident/Accident: \_\_\_\_\_

Witnesses: Name: \_\_\_\_\_ Telephone #: (\_\_\_\_) \_\_\_\_\_

Name: \_\_\_\_\_ Telephone #: (\_\_\_\_) \_\_\_\_\_

Nature of Injury: \_\_\_\_\_

Was medical treatment sought outside of school? Yes  No  Where? \_\_\_\_\_  
(If yes, fill out Medical Claim form on back of this form)

If Hospital, Was Ambulance Called? Yes  No  Ambulance Company \_\_\_\_\_

Additional Remarks: \_\_\_\_\_

Report Prepared By: \_\_\_\_\_

Title: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ Date: \_\_\_\_\_



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# MEDICAL PAYMENT CLAIM FORM

## SECTION 1: CLAIMANT INFORMATION *Please Print*

NAME OF INJURED PARTY \_\_\_\_\_ CLAIM NUMBER \_\_\_\_\_

IF MINOR, INCLUDE PARENT/GUARDIAN NAME \_\_\_\_\_

SOCIAL SECURITY NUMBER \_\_\_\_\_ GENDER \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

Exact date of injury: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Time of day: \_\_\_\_\_

Where did injury occur (include district name and building): \_\_\_\_\_

Description of incident leading to injury: \_\_\_\_\_

Part of body injured: \_\_\_\_\_

Medical treatment sought?  YES  NO When: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ to \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Where? Name of treatment facility (list all): \_\_\_\_\_

Witnesses (please provide names and contact information of all witnesses if known): \_\_\_\_\_

## SECTION 2: INSURANCE INFORMATION

Is the injured party covered by any health care coverage (including coverage under parents/guardians plan)?  YES  NO

Is the injured party covered by MEDICAID?  YES  NO

Is the injured party covered under any MEDICARE coverage?  YES  NO

NAME OF HEALTH CARE COVERAGE/PLAN \_\_\_\_\_ MAILING ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

POLICY/CONTRACT NUMBER \_\_\_\_\_ GROUP NUMBER \_\_\_\_\_ GUARANTOR NAME \_\_\_\_\_

## SECTION 3: MEDICAL AUTHORIZATION

**MEDICAL AUTHORIZATION:** I hereby state the above information is true and correct to the best of my knowledge. I authorize the release of \_\_\_\_\_ medical documentation and other information which may be in the possession of any insurer, medical provider, physician, hospital, ambulance service or nurse, to any representative of SET SEG regarding my injuries, medical history, and physical and mental condition both prior to and subsequent to the date of this authorization, regardless of lapse of time. Upon presentation of this authorization or a photocopy of the authorization, you are authorized to release a copy of my medical records to any representative of SET SEG for the purpose of investigating an insurance claim. I understand that the information disclosed pursuant to this medical authorization may NOT be re-disclosed to another party without my written consent. **THIS IS NOT A RELEASE OF MY INSURANCE CLAIM.** The purpose of the disclosure is at my request and this Medical Authorization shall be deemed to comply with the requirements of the Health Insurance Portability and Accountability Act (HIPAA). This Medical Authorization shall expire upon final resolution of my pending claim with SET SEG. I understand that I may revoke this Medical Authorization at any time by sending a written notice to my medical providers or to SET SEG.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**Please return this completed form and copies of any out-of-pocket medical bills to:**

To your building secretary OR

Lakeview School District, Attn: Business Office, 15 Arbor Street, Battle Creek, MI 49015

Phone: 269-565-2414 Fax: 269-565-2408