Mail this completed report and bills within 90 days after the first treatment to the Plan Administrator:

IS/IT Claims Administration Center
Commercial Travelers Mutual
Insurance Company
70 Genesee Street
Utica, NY 13502

For Toll-free Policyholder Service:
1-800-756-3702
Fax 315-724-6372

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 insurance company separately. Please show name of school on all later bills.
4. Explanation of Benefits from your Primary insurance carrier must accompany this claim form and any future bills.
5. Save copies of submitted materials for your records.

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 Cypress Christian School

Phone No. 281 664 0230

Address: Street/Box# 11123 Cypress N. Houston Rd

City Houston State TX Zip 77065

Check one: ☐ School Year Claim ☐ Summer School or Camp Claim

Check one: ☐ Day Student ☐ Boarding Student

Policy No. 2011I3P34

Name of Student ☐ Foreign ☐ Domestic

☐ 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 ______

Describe **HOW** the accident happened:

Details of Injury — including part of body injured:

Name of Teacher or Coach Supervising the Activity

FOR RESIDENTS OF ALL STATES OTHER THAN THOSE LISTED ON PAGE 3: Any person who knowingly, and with intent to defraud, injure or deceive any insurance company, files or causes to be filed, a claim for payment of a loss, containing any false or incomplete information commits a fraudulent insurance act that may be a crime and may subject such person to confinement in prison, fines and denial of benefits.

Signature of School Official/Title

Date Signed

—Reverse side must be completed by parent or guardian—

UNDERWRITTEN BY:
SECURITY MUTUAL LIFE INSURANCE COMPANY OF NEW YORK

Form 2010S (IS/IT)

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 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 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 Parents' Voluntary Extension 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 physician who treated you ____________

Dates treated ____________

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

____________ Phone ____________

I hereby authorize any Insurance Company, Organization, Employer, Hospital, Physician, Surgeon or Pharmacy to release any information requested by the Security Mutual Life Insurance Company of New York or its representatives. A photostatic copy of this authorization shall be as valid and effective as the original.

I also authorize Security Mutual Life Insurance Company of New York or its 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 Security Mutual Life Insurance Company of New York 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 ____________

FOR RESIDENTS OF ALL STATES OTHER THAN THOSE LISTED ON PAGE 3: Any person who knowingly, and with intent to defraud, injure or deceive any insurance company, files or causes to be filed, a claim for payment of a loss, containing any false or incomplete information commits a fraudulent insurance act that may be a crime and may subject such person to confinement in prison, fines and denial of benefits.

Signature of Parent or Guardian	Date Signed

THE BENEFIT PERIOD FOR ELIGIBLE EXPENSES IS 52 WEEKS FROM THE DATE OF THE ACCIDENT, EXCEPT COVERED DENTAL, WHICH IS 104 WEEKS