

Plan Administered by:



COMMERCIAL TRAVELERS
MUTUAL INSURANCE COMPANY
70 GENESEE STREET
UTICA, NEW YORK 13502

Please check the correct Underwriting Company:

Commercial Travelers Mutual Insurance Company
Fidelity Security Life Insurance Company

K-12 Accident Claim Form

Please print or type

Part A: School Report

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
Name of Student		Policy No.	
		Male	Female
		Grade	
Date of Accident	How Accident Occurred		
	Enroute to/from school		
	During school session		
	Practice or play of interscholastic sports		
Time of Accident	Name of Sport _____		JV Varsity
AM			
PM	Other _____		

Explain in detail how the accident happened:

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 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 (in FL, a felony in the third degree), and in the state of New York, shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Signature of School Official/Title	Date Signed
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—Part B must be completed by parent or guardian—

For Toll-free Policyholder Service

1-800-756-3702

K-12 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 / /
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Name of Person Making this Report	Relationship to Student
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Address Street/Box# City State Zip	Telephone Home () _____ Work () _____
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Name of Student's Male Parent or Guardian	Occupation	Social Security No.
Address if different from student		

Employer's Name and Address

Name	Street/Box#	City	State	Zip	Phone #
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Name of Student's Female Parent or Guardian	Occupation	Social Security No.
Address if different from student		

Employer's Name and Address

Name	Street/Box#	City	State	Zip	Phone #
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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)
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For Around-the-Clock Coverage only:
 Date of injury _____ When was physician first consulted? _____
 Nature of injury _____
 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 Insurance Company, Organization, Employer, Hospital, Physician, Surgeon or Pharmacy to release any information requested by the Insurance Company checked on Part A or its representatives. A photostatic copy of this authorization shall be considered as effective and valid as the original.

I also authorize the Insurance Company checked on Part A 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 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 (in FL, a felony in the third degree), and in the state of New York, shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Signature of Parent or Guardian	Date Signed
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