Underwritten By:

SECURITY MUTUAL
LIFE INSURANCE COMPANY
OF NEW YORK
BINGHAMTON, NY

When completed return this form to:

T.L. GROSECLOSE ASSOCIATES, INC.
190 TAMARACK CIRCLE
SKILLMAN, NJ 08558
PHONE (609)279-1507
FAX (609)279-1535

Please Check One

- ❑ Undergraduate Student
- ❑ Graduate Student
- ❑ Law Student

IMPORTANT: Please attach itemized bills. This form MUST be completed in full and returned to the company WITHIN 90 DAYS from the date of treatment accompanied by all bills received to that date. Mail to the address shown on this form. Payments will be made to the service provider unless otherwise advised.

CLAIM CANNOT BE PROCESSED WITHOUT THIS INFORMATION

College (or) University **SETON HALL UNIVERSITY**		❑ Domestic Student—Soc. Sec. # ❑ International Student—Student ID # ______			
Student's Name		Policy # ❑ **LAW - ______ -G3A45** ❑ **GRAD/UNDGRAD - ______ -G3A31**		❑ Male ❑ Female	Date of Birth
If Claim for Dependent Give Name and Relationship	Name	Relationship		❑ Male ❑ Female	Date of Birth
Student Mailing Address	Street Address	City	State	Zip	Telephone ( )

1. Date of injury (or) onset of sickness ______ When was physician first consulted? ______
   Nature of illness (or) injury ______
   If injury, (a) How and where did accident occur? ______
   (b) Were you practicing or playing any intercollegiate (between rival colleges) sport at the time of the accident? ❑Yes ❑No
   Club Sport? ❑Yes ❑No If "Yes," name sport ______
   (c) IF AN INTERCOLLEGIATE ACCIDENT, THIS FORM MUST BE SIGNED BY THE ATHLETIC DEPARTMENT
   I certify the above accident resulted from the supervised practice or play or travel to and from an intercollegiate sport.

   ______
   Signature of Athletic Department Official Title Date
2. Were you treated and/or referred by the Student Health Service? ❑Yes ❑No If "Yes," date ______
3. Hospital (Give name, address and date of confinement) ______
   From / / To / /
4. Give names, addresses and telephone numbers of all attending physicians ______
   ______ Phone ______
5. Give name, address and telephone number of usual family physician ______
   ______ Phone ______
6. Have you suffered same or similar condition in the past? ❑Yes ❑No If "Yes," and you were treated for it, please give name and address of the physician who treated you ______
   Dates treated ______
   If hospitalized at that time: Name of hospital ______
   Address ______ Dates Confined ______
7. Was injury the result of a motor vehicle accident? ❑Yes ❑No
8. Do you, your spouse or your parents have other insurance or medical plan which covers this condition, either group, individual, automobile, medical or liability?
   ❑ Yes ❑No If so, give name of Company: ______

Father's Name	SS#	Father's Employer-Name	Address	Phone #
Mother's Name	SS#	Mother's Employer-Name	Address	Phone #
Spouse's Name	SS#	Spouse's Employer-Name	Address	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 Security Mutual Life Insurance Company of New York or its authorized benefit plan administrator. A photostatic copy of this authorization shall be as valid 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.

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. (This notice is not applicable in VA.)

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 ______ Date ______

Signature of claimant (parent or guardian if not adult) ______

Student's Address While at School ______
Street City State Zip

CCF-2002 (SML/TLG)