

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

<input type="checkbox"/> Undergraduate Student
<input type="checkbox"/> Graduate 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		<input type="checkbox"/> Domestic Student—Soc. Sec. # _____	
		<input type="checkbox"/> International Student—Student ID # _____	
Student's Name		Policy # -G3A31	<input type="checkbox"/> Male <input type="checkbox"/> Female
			Date of Birth _____
If Claim for Dependent Give Name and Relationship	Name	Relationship	<input type="checkbox"/> Male <input type="checkbox"/> 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 _____