STUDENT MEDICAL INSURANCE REFERRAL FORM

Return this form with copies of all bills showing dates of service or treatment

POLICY NO: 2006-1103
Underwritten by: The MEGA Life and Health Insurance Company

MAIL COMPLETED FORM TO:
Klais & Company, Inc.
1867 West market Street
Akron, Ohio 44313

Student Name: ____
Social Security # ______________________________ Date of Birth: _____________ ___ Male ___ Female
Current Address: ____
(Street) *(City)* *(State)* *(Zip Code)*

If claim is for dependent, Name of dependent:____

__ Male __ Female Date of Birth: _______________ Relationship: ____________________________

PLEASE COMPLETE THE FOLLOWING:

1. Date of Injury (or) onset of Sickness: _________________ When was physician First Consulted? (Date) ______________

2. Nature of Injury (or) Illness: ____

3. If Injury, (a) How and where did accident occur? ____
(***Please use back of Claim Form if needed***)

(b) Were you practicing or playing any intercollegiate (against another college) sport at the time of the accident? ___Yes ____ No

If "Yes", name the Sport: ____
****If an intercollegiate sports 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: ____

4. **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.**
Name: ____ Date Treated: ______________________
Address: ____

5. Was injury the result of a motor vehicle accident? ___Yes ___No

6. Did the injury happen while Employed? ___ Yes ___ No

HEALTH CENTER REFERRAL: (Remember to use a Network Provider)
Date Seen at Health Center ____________________ Authorized Signature or Initial ________________________

Referring Physician ____

___ I did not go to the Health Center because: (Please check one)
____ I was not in the Area ____ It was an emergency ____ The Health Center was closed

___ Other ____
(Give Reason)

7. Do you, your spouse or your parents have any other insurance or medical plan that covers this condition, either Group, Individual Automobile, Medical or Liability? __Yes __No If "Yes", provide name and address of company:

____

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 MEGA Life and Health Insurance Company or its authorized benefit plan administrator. A photocopy of this authorization shall be as valid as the original. I agree that all information can result in duplicate payments creating a substantial overpayment. Such overpayment will be the obligation of the undersigned, with responsibility to reimburse in full, upon request, all amounts deemed refundable. **Any person who intentionally includes false or misleading information in an attempt to defraud or deceive is guilty of a crime. 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.**