Plan Administered by:

COMMERCIAL TRAVELERS MUTUAL INSURANCE COMPANY
COMMERCIAL TRAVELERS BUILDING
UTICA, NEW YORK 13502

For Toll-free Policyholder Service 1-800-756-3702 • Utica area 315-797-5200

Please check the correct Underwriting Company:

☒ COMMERCIAL TRAVELERS MUTUAL INSURANCE COMPANY
☐ NIAGARA LIFE AND HEALTH

Notice: When we are the secondary plan, we do not pay until after the primary plan has paid its benefits if any. We will review Usual & Customary charges of each plan and allow the highest. Any amount paid by your primary plan for an eligible expense under our plan may satisfy all or a portion of our deductible.

Instructions
- School Official completes Part A.
- Parent/Guardian completes Part B. The Claim Form must be fully completed. Forms not fully completed may cause the Claim Representative to return the Claim Form resulting in processing delays.
- Please submit the completed Claim Form within 90 days from the date of accident.
- Submitting the appropriate documentation is essential for timely adjudication of your claim expenses. Note: If you are receiving treatment from a provider (primary care physician), please request a CMS 1500. If you are receiving treatment from a hospital, please request a UB04.
- Please submit any Notice of Payment or Rejection (explanation of benefits—EOB) forms from your health insurance carrier. Any itemized billing statements submitted must include a diagnosis code and procedure code.
- Please notify all physicians, hospitals and any other healthcare providers that have or will be treating your child and provide them with these instructions. Please ask the providers to forward bills to the claims administrator at:

Commercial Travelers Mutual Insurance Company
Attn: K-12 Claim Administration • 70 Genesee Street Utica NY 13502
Fax No. 315-797-0195

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: Duanesburg CSD
School District/Policyholder: SAME — DCS 133 School Dr Delanson NY 12053
Phone No.
Address
Street/Box# City State Zip
Policy No. 2016 FA A22
Name of Student
☐ 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 _____

How did accident happen?

Details of Injury — including part of body injured ☐ Left ☐ Right: _____

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 health insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, any information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed $5,000.00 and the stated value of the claim for each such violation.

Signature of School Official/Title
Date Signed

—Reverse side must be completed by parent or guardian—

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 | Telephone
Home ( ) _____
Street/Box# City State Zip | Work ( ) _____

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 #

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 #

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)

or Around-the-Clock 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 the physician who treated you _____

Dates treated _____

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

_____ 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 Insurance Company checked on the reverse or its authorized benefit plan administrator. A photostatic copy of this authorization shall be as valid as the original.

I also authorize the Insurance Company checked on the reverse 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 _____

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Signature of Parent or Guardian	Date Signed