PAN AMERICAN LIFE INSURANCE GROUP

NAHGA CLAIM SERVICES
WHERE STELLAR SERVICE IS NO ACCIDENT

ACCIDENT CLAIM FORM

This policy is secondary coverage to all other policies, except as required by state or federal law.

SEND COMPETED FORM & BILLS TO:

Claim Forms to: STUDENT INSURANCE
A VENBROOK COMPANY

6320 Canoga Ave., 12th Floor
Woodland Hills, CA 91367
Email to: claims@studentinsuranceusa.com
Fax: 1-310-826-1601

INSTRUCTIONS

- All fields must be completed
- Part 1 – Must be completed by the Policyholder
- Part 2 and 3 – Must be completed by Claimant or by the Parent or Guardian, if the Claimant is a minor
- Send copies of itemized bills showing provider's name, address, tax ID number, diagnosis and procedures codes.
- Attach explanation of benefits, additional bills with record of payment or denial from primary insurance carrier. This does not apply if the accident policy provides primary coverage
- All benefits will be payable to the physicians and providers, unless accompanied by paid receipts

PART 1 – POLICYHOLDER REPORT

1)	Name of Policyholder (SCHOOL DISTRICT)	Merced Community College
2)	Policy Number (COLLEGE)	98390
3)	Policyholder Address	3600 M St, Merced, CA 95348
4)	Policyholder Contact's Email Address	Kimberly Rowan
5)	Policyholder Contact's Phone Number	310-826-5688
6)	Nature of Injury (Describe, fully indicate what part of the body was injured) **Must be a bodily injury due to an Accident**	
7)	Describe how the accident occurred, provide all details **Attach a separate sheet, if necessary**	
8)	Did the Accident occur:	
	a. During a Policyholder supervised sponsored activity	☐ Yes ☐ No
	b. During a Policyholder sponsored activity	☐ Yes ☐ No
	c. During scheduled Policyholder hours	☐ Yes ☐ No
	d. While traveling to or from a Policyholder sponsored or supervised activity	☐ Yes ☐ No
	e. While Traveling to or from the Policyholder's location and their home	☐ Yes ☐ No
9)	Date and Time of Accident	
	Place of Accident	
10)	Name and Title of Person Supervising Activity	
	Was he or she a witness	☐ Yes ☐ No

Signature of Authorized Policyholder Representative	Title	Date

PART 2 – CLAIMANT / PARENT OR GUARDIAN INFORMATION

1) Claimant's Name (Last, First) (Student)	
2) Claimant's Student ID Number	
3) Claimant's Date of Birth	
4) Claimant's Sex	☐ Male ☐ Female
5) Name of Parent / Guardian if under 18	
~~6) Parent / Guardian's Social Security Number~~	SSI Numbers are not used at the college
7) Student's Email Address	
8) Student's Address	
9) List other Accident or Medical Insurance currently enforce (Attach a separate sheet if necessary) **Type of Policy and Policy Number**	
10) Is the Claimant covered by a Medi-cal, or Medicare Policy	☐ Yes ☐ No

PART 3 – AUTHORIZATION

PERSONAL INFORMATION NOTICE AND CONSENT: I understand that the information provided by me on this claim form and otherwise in respect of my claim, is required by Pan-American Life Insurance Company or its representatives (the "Insurer") to assess my entitlement to benefits, determine if coverage is in effect and co-coordinate coverage with other insurers. I consent to the collection, use, retention and disclosure of my personal information and that of my dependents, including any information collected in this claim form or otherwise obtained by the Insurer, its affiliates and any independent third parties for the purposes of administering, adjudicating, and/or servicing my claim as well as exchanging information with agents, brokers, third party administrators or any other independent third parties for the purposes of determining the status, outcome or resolving any issues in connection with my claim. I understand that my personal information and that of my dependents may be stored within or outside the United States for processing, storage, analysis, or disaster recovery, and under applicable law, may be subject to disclosure to domestic or foreign governments, courts, law enforcement or regulatory agencies. I understand that I may revoke my consent at any time in writing and acknowledge that should I do so, my claim may not be adjudicated. In cases of suspected fraud concerning this claim, I agree that the Insurer may investigate and share information with regulatory bodies, government or police agencies, other insurers, healthcare professionals, the group policyholder or my employer, if applicable.

I, the undersigned authorize any hospital or other medical-care institution, physician or other medical professional, pharmacy, insurance support organization, governmental agency, group policyholder, insurance company or reinsurance company, workers compensation board or similar plan or organization, association or institution, employer or benefit plan administrator to furnish to Pan-American Life Insurance Company or its representatives, any and all information with respect to any injury or sickness suffered by, the medical history of, or any consultation, prescription or treatment provided to, the person whose death, injury, sickness or loss is the basis of claim and copies of all of that person's hospital or medical records, including information relating to mental illness and use of drugs and alcohol, to determine eligibility for benefit payments under the Policy Number identified above. I authorize the group policyholder, employer or benefit plan administrator to provide Pan-American Life Insurance Company with financial and employment-related information. I understand that this authorization is valid for a period of two (2) years from the date hereof, and that a copy of this authorization shall be considered as valid as the original. I understand that I or my authorized representative may request a copy of this authorization.

Signature of Claimant or Parent or Guardian	Date

AUTHORIZATION TO PAY BENEFITS TO PROVIDER: I hereby authorize payment directly to the Provider of service for medical benefits, if any, otherwise payable to me for services rendered but not to exceed the reasonable and customary charge for those services.

Signature of Claimant or Parent or Guardian	Date

Note: If you do not sign the authorized to pay benefits to the provider and would like payment directly to you, you MUST submit paid receipts for each bill.