Rochester Institute of Technology – Policy # 812809
CLAIM FORM

PLEASE RETURN THIS COMPLETED FORM AND RELATED BILLS TO:
Aetna Student Health, P.O. Box 15708 Boston, MA 02215

Please Note: *The RIT Excess Accident Plan provides secondary insurance coverage for accidents occurring on campus or off campus at an RIT sponsored activity. All bills must first be submitted to any other medical insurance plan(s) to which the student may be eligible.* ***The primary Insurer's Explanation of Benefits indicating payment or rejection of charges must be submitted with each claim for benefit consideration.***

Part 1 STUDENT INFORMATION (Failure to complete this section completely may delay the processing of the claim.)

Last Name	First Name	Middle Initial	Date of Birth (MM/DD/YY)	Student ID Number

Local address of Student (Street, City, State and Zip Code)	Phone Number

Is Student Insured under any other Insurance Plan		
☐ Yes ☐ No	☐ Undergraduate ☐ Graduate ☐ Co-Op Student	☐ Male ☐ Female

*** If "YES", please attach copies of statements of benefits paid or denied and complete the following:**

Name of Insurance Company	Phone number	Effective date
Name of Person Carrying Other Insurance Coverage	**Plan or Group Number**	**Subscriber ID /Policy Number**

Part 2 THIS SECTION TO BE COMPLETED FOR AN ACCIDENT CLAIM

Sport	Was student involved in school sponsored event: ☐ Yes ☐ No	Date of Injury	Time of Injury

Description of Injury (What happened, how and where)

Sport designation:
☐ Intercollegiate ☐ Practice ☐ Game ☐ Other: (explain)

Name and Title of Supervising Official	Was He/She a witness: ☐ Yes ☐ No	If Accident is NCAA sanctioned intercollegiate sport related please attach verification from athletic trainer.

Part 3 THIS SECTION TO BE COMPLETED FOR A SICKNESS CLAIM

Description of Sickness or Condition (Nature of condition, date symptoms first noticed)

If your claim is for services outside of the RIT Student Health Center, were you referred? ☐ Yes ☐ No	If not, why? ☐ Away from school ☐ Health Center closed ☐ Other: (explain)	Date of First Treatment

MEDICAL INFORMATION AUTHORIZATION

I hereby authorize any licensed physician, hospital, clinic or other medically related facility, insurance company or other organization, institution or person that has any records, including any medical history of the above named person suffering loss, to furnish such information or copies of records to Aetna Student Health. A photographic copy of this authorization shall be as valid as the original. I can certify that the information given by me in support of this claim is true and correct. I further understand that any person who knowingly and with intent to defraud any insurance company or other person files a 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.

SIGNED ______________________________ **DATE** ____________________
Student Signature (Parent or Guardian, if under 18)

Printed Name and Relation of Parent or Guardian if signing Claim Form on behalf of Student:	Parent/Guardian Phone Number