Return completed claim form to:
Student Insurance
600 Lincoln Avenue · Charleston, IL 61920
Phone 217-581-5290
Fax 217-581-7507

IMPORTANT - YOUR CLAIM WILL BE DENIED IF THIS FORM IS NOT FULLY COMPLETED

Name of the student (Last, First, MI)	Date of Birth	Age

Permanent home address (Number, Street, City, State, and ZIP Code)	E-Number
Local address (Number, Street, City, State, and ZIP Code)	Cell Phone number

REQUIRED - What condition/illness/injury will/did you visit a medical provider for?

When did your symptoms first appear or accident happen? Date:_____/_____/_____Time:_____	Were you treated and/or referred by the Health Service for this condition? ☐ Yes. ☐ No.

If injury, describe how and where accident occurred - give complete details (use additional pages if necessary).

If a motor vehicle injury, list names of all driver and companies insuring all driver and/or vehicles.

If injured during practice or play of sports, what sport was involved? Check one: ☐ Intramural. ☐ Intercollegiate athletics. ☐ Other.

Name and address of doctor, hospital, or other providers of care for this injury or illness (use additional pages if necessary).

**It is the student's responsibility to provide primary insurance information (if applicable) and EIU Student Insurance information to all providers to have insurance billings submitted to the EIU Student Insurance office.

REQUIRED - Do you have any other insurance which covers this condition, either group, individual, automobile medical or liability? ☐ No. ☐ Yes. If Yes, give the following data.

Name of the insurance company		Insurance company address	
Name of policy holder	Group number	I.D. Number	Insurance company phone

If group coverage through parent, spouse, or individual employer plan - list employer name and address.

Disclosure of Authorization for Release of Medical Records (Patient/students responsibility to complete)

It is the Student's responsibility to furnish the Student Insurance Office with the claim form, itemized bills of expenses and explanation of benefits from primary carrier (if applicable) as soon as possible, but no later than 52 weeks from the first date of the medical expenses. Claims submitted after 52 weeks from date of medical expense will be denied. Upon presentation of the original or photo copy of this authorization, I authorize any medical professional, hospital, clinic, or other medical or medically related facility, government agency, or other person or firm to provide information including copies of records concerning advice, care or treatment provided to me including, without limitation, information relating to mental illness, use of drugs or alcohol, to Eastern Illinois University representatives involved in evaluating, determining or administering claims for insurance benefits for me. I understand that any authorized representative or I will receive a copy of this authorization upon request. This authorization is valid from the date signed through the term of coverage of the policy or during the period to process the claims.

Name (print) Signature Date