MARKEL INSURANCE COMPANY

STATE STATUTES SPECIFY: "Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation."

COMPLETE AND MAIL TO:

POMCO
P. O. Box 186
Syracuse, NY 13206-0186
(866) 834-4765

Claim procedures and online access to our claim form are available from our website at:

www.markelmedical.com

CLAIM CANNOT BE PROCESSED WITHOUT THIS INFORMATION

COLLEGE (OR) UNIVERSITY			POLICY #		SOC. SEC. #
STUDENTS NAME				MALE ☐ FEMALE ☐	AGE
IF CLAIM FOR DEPENDENT GIVE NAME AND RELATIONSHIP				MALE ☐ FEMALE ☐	AGE
STUDENT / DEPENDENT FULL ADDRESS (WHILE AT SCHOOL)	STREET ADDRESS	CITY	STATE	ZIP	TELEPHONE
FULL ADDRESS (HOME)	STREET ADDRESS	CITY	STATE	ZIP	TELEPHONE

(1) Date of injury (or) beginning of sickness _____ When physician first consulted? _____

Type of illness (or) injury _____

If pregnancy, please indicate your last menstrual period (LMP) date: _____

If injury, (a) How did accident occur? _____

(b) Where did accident occur? _____

(c) Were you practicing or playing **any** intercollegiate (between rival colleges) sport at the time of the accident? ☐ Yes ☐ No

Club Sport? ☐ Yes ☐ No Intramural Sport? ☐ Yes ☐ No If "Yes," name sport: _____

(2) Were you treated by the Student Health Service? ☐ Yes ☐ No If "Yes," date: _____

Were you referred by the Student Health Service? ☐ Yes ☐ No If "Yes," date: _____

If "No," was the Student Health Service closed? ☐ Yes ☐ No

(3) Hospital: (Give name, address and date of confinement) _____

_____ From / To _____

(4) Give names, addresses and telephone numbers of all attending physicians _____

_____ Phone (___) _____

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

_____ Phone (___) _____

(6) Have you suffered same or similar condition in the past? ☐ Yes ☐ No If "Yes" and you were treated for it, please give name and address of the physician who treated you: _____ Dates Treated: _____

If hospitalized at that time: Name of Hospital: _____

Address _____ Dates Confined: _____

(7) DO YOU HAVE OTHER INSURANCE WHICH COVERS THIS CONDITION, EITHER GROUP, INDIVIDUAL AUTOMOBILE, MEDICAL OR LIABILITY? ☐ Yes ☐ No IF YES, HAVE THESE CHARGES BEEN SUBMITTED THROUGH YOUR OTHER CARRIER? ☐ Yes ☐ No

(8) Is condition due to injury or sickness arising out of your employment? ☐ Yes ☐ No

AUTHORIZATION REGARDING PAYMENT OF BENEFITS

For services rendered or to be rendered I hereby authorize MARKEL INSURANCE COMPANY or their representatives to pay benefits in connection with this accident or illness direct to the doctor, hospital or other rendering service. If receipted bills are submitted, the benefits are to be paid to:

AUTHORIZATION TO OBTAIN INFORMATION

I AUTHORIZE any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance or reinsuring company, the Medical Information Bureau, Inc., consumer reporting agency, or employer having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me or my minor children and any other non-medical information of me or my minor children to give to MARKEL INSURANCE COMPANY or its legal representative, any and all such information.

I UNDERSTAND the information obtained by use of the Authorization will be used by MARKEL INSURANCE COMPANY to determine eligiblity for insurance, and eligiblity for benefits under any existing policy. Any information obtained will not be released by MARKEL INSURANCE COMPANY to any person or organization EXCEPT to reinsuring companies, the Medical Information Bureau, Inc., or other persons or organizations performing business or legal services in connection with my application, claim, or as may be otherwise lawfully required or as I may further authorize.

I KNOW that I may request to receive a copy of this Authorization.
I AGREE that a photograhic copy of this Authorization shall be as valid as the original.
I ACKNOWLEDGE receipt of the Notice of Disclosure of Information and Notice to Persons Applying for Insurance.
I AGREE this Authorization shall be valid for two and one-half years from the date shown below.

Signed this _____ day of _____, 20_____

_____ Name of Minor Child

_____ Signature of Insured

ATTENDING PHYSICIAN'S STATEMENT - HEALTH INSURANCE CLAIM
ACCIDENT OR SICKNESS

PATIENT'S NAME AND ADDRESS | MALE ☐ FEMALE ☐ | AGE

(1a) Diagnosis and Concurrent Conditions (If fracture or dislocation. describe nature and location): _____

(b) If pregnancy, please indicate the patient's last menstrual period (LMP) date: _____

(c) Is condition due to injury or sickness arising out of patient's employment? ☐ Yes ☐ No If "Yes," explain: _____

(d) Describe any other disease or infirmity affecting present condition: _____

(2a) When did symptoms first appear or accident happen? Date _____, 20_____

(b) When did patient first consult you for this condition? Date _____, 20_____

(c) Has patient ever had same or similar condition? ☐ Yes ☐ No If "Yes," state when and describe: _____

(d) If patient referred by other doctor, give name and address of such doctor: Name: _____

Address: _____ City: _____ State: _____ Zip: _____

(3a) Nature of surgical or obstetrical procedure, if any (describe fully): (Please give CPT Procedure Code) _____

(b) Charge to patient for this procedure including postoperative care: Date performed _____, 20_____ $ _____

(c) If performed in hospital, give name of hospital: _____ ☐ Inpatient ☐ Outpatient

(4a) Give dates of other (non-surgical) treatment, if any: _____

(b) If patient hospitalized, give confinement dates, name and address of hospital: _____

(4c) CHARGE PER CALL

Office _____ $ _____

Home _____ $ _____

Hospital _____ $ _____

Nursing Home _____ $ _____

Total (non-surgical) charges $ _____

(5) What other services, if any did you provide patient? (Itemize, giving dates and fees): _____

(6) Were registered private duty nurse (RN) services necessary? _____

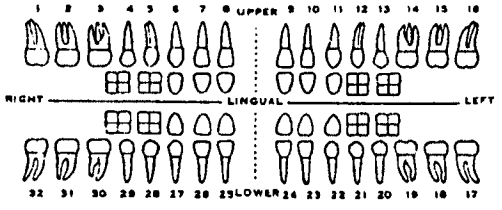
(7) Is patient still under your care for this condition? ☐ Yes ☐ No If "No," give date your services terminated: _____, 20_____

(8) Did you file this claim with any other Insurance Company? ☐ Yes ☐ No If "Yes," indicate name and address of company: _____

(ANSWER ALL QUESTIONS ABOVE, IN ADDITION TO THOSE BELOW, IF DENTISTRY.)

DENTAL

1. State exactly which teeth were involved in the accident and indicate them on chart: _____



INJURY

2. Describe exact nature of injury.
3. Describe condition of injured teeth prior to accident:
   ☐ Whole, Sound and Natural ☐ Filled ☐ Capped ☐ Artificial
4. Comments _____

REMARKS

DATE | SIGNATURE (Attending Physician: Please Print) | DEGREE

I.R.S., I.D., or S.S. # | TELEPHONE

STREET ADDRESS | CITY | STATE | ZIP CODE