



# STUDENT INJURY CLAIM FORM

2016-2017 PLAN YEAR  
EFFECTIVE DATE: JULY 1, 2016

Policy Number: IHH000309

District Name: \_\_\_\_\_ School Name/Location #: \_\_\_\_\_

School Address: \_\_\_\_\_ School Phone #: \_\_\_\_\_

Student's Name \_\_\_\_\_  
FIRST NAME MIDDLE INITIAL LAST NAME

Date of Birth \_\_\_\_\_ Sex:  M  F Parent's Day Time Phone \_\_\_\_\_

Parent's Address \_\_\_\_\_  
STREET CITY STATE ZIP

## INJURY INFORMATION

Cause of Injury \_\_\_\_\_ Injury Date \_\_\_\_\_

Body Part Injured \_\_\_\_\_ Place of Injury \_\_\_\_\_

Nature of Injury — Details of What Happened \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### District/School Certification Signature Required:

I hereby certify the student is enrolled in school and the injury was sustained under adequate supervision while participating in a school sponsored activity.

\_\_\_\_\_  
Title of District/School Official Signature of District/School Official Date

..... District to Complete the Above Information .....

### INSURANCE INFORMATION (TO BE COMPLETED BY PARENT OR GUARDIAN)

Does the parent/guardian have medical/health insurance?  Yes  No (Attach separate sheet if necessary.)

Insurance Company Name & Address \_\_\_\_\_

Policy Number \_\_\_\_\_ ID# \_\_\_\_\_

### Parent / Guardian Certification Signature Required:

I authorize any physician/hospital that has attended my dependent child to disclose information thus acquired for the purpose of this claim payment. I hereby certify the above statements made by and certified by me to be true to the best of my knowledge.

Parent's Email Address: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_

\_\_\_\_\_  
Signature of Parent / Guardian

\_\_\_\_\_  
Printed Name Parent / Guardian Date

**To process your claim, you will need to submit the following pieces of information:**

1. The completed and signed "Student Injury Report"
2. All Itemized Bills and Explanations of Benefits (EOBs) from Your Primary Insurance Company

Submit all documents via fax, email or US mail to:

**A-G Administrators, Inc.**  
**PO Box 979**  
**Valley Forge, PA 19482**  
**Phone: 800-634-8628**  
**Fax: 610-933-4122**  
**Email: [claims@agadm.com](mailto:claims@agadm.com)**

**FRAUD WARNING:** Any person who, knowingly and with intent to defraud, or helps commit a fraud against, any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits or may be committing a fraudulent insurance act, which is a crime and subjects such person to criminal and/or civil penalties. For residents of the following states, please see below: California, Colorado, District of Columbia, Florida, New York, Tennessee, Texas or Virginia.

**California & Texas Residents:** Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.