Myers-Stevens
26101 Marguerite Parkway
Mission Viejo, CA 92692-3203
1-800-827-4695 Fax 949-348-2630

Instructions:
1) Complete this form
2) Attach all bills
3) Mail to: Myers-Stevens

STUDENT ACCIDENT COVERAGE – ACCIDENT CLAIM FORM

PART A ~ SCHOOL STATEMENT

1 Injured Student Name: First MI Last	Student Soc. Security #	Student DOB:
2 Name of AML/JIA Member School District:	Student Age & Grade:	☐ Male ☐ Female
3 Injury Occurred: ☐ practice ☐ game ☐ P.E. ☐ classroom ☐ travel ☐ field trip ☐ at home ☐ other	Date of Injury: month/day/year	Time of Injury:
Details on how the injury occurred: (please be specific)	What part of the body was injured?	School telephone number: School FAX number:
4 Name of Supervisor/Teacher (school):	Date school was notified of incident:	Did Supervisor/teacher witness incident?
5 Name of Official/Superintendent/Principal	Signature of official: **x**	Date Signed:

PART B ~ PARENT OR GUARDIAN STATEMENT

6 Relationship to Injured Student: ☐ Father ☐ Mother ☐ Guardian ☐ Other	Is this dependent covered by another health and/or accident insurance plan? ☐ Yes ☐ No

7 Name of **Father or Male** Guardian:	SSN:	Home Telephone Number: ( )
Address:	City/State:	Zip Code:
8 Name of Employer:	Work Telephone Number: ( )	
Address of Employer:	City/State:	Zip Code:
9 Name of other health/accident coverage:	Policy Number:	Telephone Number: ( )
10 Address of other coverage:	City/State:	Zip Code:
11 Name of **Mother or Female** Guardian:	SSN:	Home Telephone Number: ( )
Address:	City/State:	Zip Code:
12 Name of Employer:	Work Telephone Number: ( )	
Address of Employer:	City/State:	Zip Code:
13 Name of other health/accident coverage:	Policy Number:	Telephone Number: ( )
14 Address of other coverage:	City/State:	Zip Code:

15 Name, address and telephone number of family physician:

16 Has the student suffered from same or similar condition before?
☐ Yes ☐ No If Yes, when?

I understand that any parent who knowingly, and with intent to defraud any insurance company or other person, files a statement of a claim containing any materially false information, or conceals, for the purpose of misleading, information concerning facts material, thereto commits a fraudulent act, which is a crime, and may subject such person to fines and/or imprisonment.	Signature of Parent or Guardian: **x**
I hereby authorize any school authority, employer, or insurance company, or person who has attended to or examined the claimant to disclose to Myers-Stevens & Toohey & Co., Inc. or the AMLJIA, when requested to do so, any information regarding any injury or illness, policy coverage, medical history, consultation, prescription or treatment, and copies of all hospital or medical records or itemized bills, and to pay benefits based upon this information. Photocopy of this authorization shall be considered as valid and effective as the original.	Relationship to injured student:
Authorization to pay benefits to provider: I authorize payment of Medical payments to Physician or Supplier for services on the attached.	Signature of Parent or Guardian: **x**