STUDENT ACCIDENT CLAIM FORM

SUBMIT CLAIM FORM TO: **Fidelity Security Life Insurance Company**
c/o Universal Fidelity Life Insurance Company
P. O. Box 304, Duncan OK 73534-0304
Phone: (800) 366-8354 Fax: (580) 252-3449
Email: SAclaims@uflic.com

Section 1 - Notice of Injury **(To be completed by School Official)**

Name of School District:

Name of School: School Phone No:

Name of Injured Student: ☐ Male ☐ Female Grade:

Date of Injury: Time of Injury: ☐ AM ☐ PM

Part of Body Injured: ☐ Right Side ☐ Left Side

Under whose supervision?

Was accident witnessed? ☐ Yes ☐ No If "Yes", by whom?

The accident happened while the student was participating in:
☐ Interscholastic UIL Activity ☐ Non Interscholastic UIL Activity

Specify Sport or Activity: _____

Explain in detail how and where the injury occurred: _____

_____

_____

_____

Signature of School Official: _____
(Title) (Date)

******** SEE REVERSE SIDE FOR IMPORTANT CLAIM FILING INSTRUCTIONS ********

Section 2 - Parent/Guardian Statement **(To be completed by Parent/Guardian)**

Name of Student: Date of Birth: Home Phone No:

Is student covered by any insurance plan? ☐ Yes ☐ No If yes: Personal ☐ Medicaid ☐ Other ☐
Name of Other Insurance:

Parent/Guardian Name: Relationship to Student:

Mailing Address: _____
(Street/P. O. Box) (City) (State) (Zip)

Father's Name: Father's Employer:

Name of Father's Insurance Company (Must be completed - If father has no insurance - write "None") **Does this policy insure the student?**

Insurance Company: Yes_____ No_____

Mother's Name: Mother's Employer:

Name of Mother's Insurance Company (Must be completed - If mother has no insurance - write "None") **Does this policy insure the student?**

Name of Insurance Company: Yes_____ No_____

I hereby authorize any insurance company, their authorized agent, hospital, physician, employer, school official or other person who has attended or examined the claimant to disclose, when requested to do so, all information with respect to any injury, policy coverage, medical history, consultation, prescription or treatment, and copies of all hospital or medical records and itemized bills. A photo static copy of this authorization shall be considered as effective and valid as the original. I swear that the above information is true and correct to the best of my knowledge. **Any person who with intent to defraud or knowing that he or she is facilitating a fraud against an Insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.**

_____ _____ _____
(Date) **(Print Name of Student)** **(Signature of Parent/Guardian)**