P.O. Box 979
Valley Forge, PA 19482
610.933.0800
Fax: 610.935.2860
www.agadministrators.com

Temple University Health Professional Schools

Accident Medical Insurance Plan Claim Form

Please complete and submit to A-G Administrators with itemized medical bills and primary insurance explanation of benefits.
For questions, please contact A-G Administrators.
For any questions or more information about the plan, visit www.temple.edu/hr/students/accident.htm

Student's Name _____
FIRST NAME MIDDLE INITIAL LAST NAME

Graduate School _____ TUid _____

Date of Birth _____ Sex: ❑ Male ❑ Female Cell Phone _____

LAST FOUR DIGITS SOCIAL SECURITY #

Email Address _____

School Address _____
STREET CITY STATE ZIP

Home Address _____
STREET CITY STATE ZIP

ACCIDENT INFORMATION

Activity _____ Accident Date _____

Body Part Injured _____ Place of Accident _____

Nature of Injury — Details of What Happened _____

_____

_____

INSURANCE INFORMATION

Does the claimant have primary insurance? ❑ Yes ❑ No *(Attach separate sheet if necessary.)*

Insurance Company Name & Address _____

Policy Number _____ ID# _____

AUTHORIZATION

AFFIDAVIT: I verify that the statement on other insurance is accurate and complete. I understand that the intentional furnishing of incorrect information via the U.S. Mail may be fraudulent and violate federal laws as well as state laws. I agree that if it is determined at a later date that there are other insurance benefits collectible on this claim I will reimburse A-G Administrators to the extent for which A-G Administrators would not have been liable.

AUTHORIZATION TO RELEASE INFORMATION: I authorize any Health Care Provider, Doctor, Medical Professional, Medical Facility, Insurance Company, Person or Organization to release any information regarding medical, dental, mental, alcohol or drug abuse history, treatment or benefits payable, including disability or employment related information concerning the patient, to A-G Administrators and its designees.

PAYMENT AUTHORIZATION: I authorize all current and future medical benefits, for services rendered and billed as a result of this claim, to be made payable to the physicians and providers indicated on the invoices.

_____ _____

STUDENT'S SIGNATURE *(Parent or guardian, if participant is a minor)* Date