

# CLAIMS QUESTIONNAIRE



**Important: An incomplete questionnaire could result in the delay of processing your claim.**

Administered by: The Lewer Agency, Inc.

Name: \_\_\_\_\_ Date of Birth (mm/dd/yyyy): \_\_\_\_\_  
Name of school: \_\_\_\_\_ Insurance I.D. Number: \_\_\_\_\_  
E-mail Address: \_\_\_\_\_

**Please fill out one of the two options below:**

**If your claim was a result of an injury, please complete the following:**

How did your injury or accident occur? (Answer below)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Was injury the result of participation in Intercollegiate College Sports?  Yes  No If yes, which sport? \_\_\_\_\_

If no, was injury the result of participation in Intramural/Club Sports?  Yes  No If yes, which sport? \_\_\_\_\_

Was your injury the result of a car accident?  Yes  No If yes, please attach a copy of the official police report and your drivers license.

Date of injury or date your symptoms were first noticed: \_\_\_\_\_

**- OR -**

**If your claim was a result of sickness, please complete the following:**

Have you ever been treated for this condition before?  Yes  No

If yes, when were you first seen or treated by the doctor for this condition? \_\_\_\_\_

List all medications that you are currently taking: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Do you have any other insurance (school insurance, travel insurance, auto insurance, spouse's insurance)?  Yes  No

If yes, have you filed a claim?  Yes  No

List the insurance company's name, address, phone number and policy number(s):  
\_\_\_\_\_  
\_\_\_\_\_

**If you are not the student, please fill out the following:**

Name: \_\_\_\_\_ Relationship to student:  Spouse  Child  Guardian

**I AUTHORIZE** any physician, medical practitioner, hospital, clinic, other medical related facility, insurance or reinsuring company, the Medical Information Bureau, Inc., consumer reporting agency, employer, school, or third party administrator, having information as to diagnosis, treatment and/or prognosis of any of my physical or mental conditions (and any of my non-medical information necessary to the processing of claims), to give THE LEWER AGENCY, INC., or their legal representatives, any and all such information. I specifically consent to the release of any of the above information which may be protected under the Family Educational Rights and Privacy Act including without limitations records of enrollment, attendance or payment of tuition related to my attendance at any Educational Institution to THE LEWER AGENCY, INC., or their legal representatives. **I UNDERSTAND** the information obtained with this Authorization will be used to determine my eligibility for coverage and/or benefits under a LewerMark insurance plan. Any such information will not be released by THE LEWER AGENCY, INC., except to the third party administrator, reinsuring companies, or other persons or organizations performing services in connection with the plan, or as may be otherwise lawfully required. **I AGREE** that: a copy of this Authorization shall be as valid as the original; this Authorization shall be valid for twelve months from the date shown below, or for the duration of this claim, if longer; and I am aware that I may request a copy of this Authorization.

**I HEREBY AUTHORIZE** payment of benefits, if any, directly to my Medical Providers for this claim.

X \_\_\_\_\_  
PATIENT'S SIGNATURE DATE

In order to electronically sign and submit this document, the Student must type his/her name and Insurance ID Number in the space provided. **Note: by signing and submitting this document, the submitter certifies that he/she is the Student insured under the insurance coverage.** Any person who knowingly and with intent to defraud files a statement of claim containing any materially false information commits a fraudulent insurance act, which is a crime, and may subject such person to criminal and civil penalties. If you are not the student, do not electronically submit this form.

If the Student is under (18) years of age or incapacitated, the Parent or Guardian must physically sign this form. If the Student is deceased, a Personal Representative or next of kin must sign.