Summit America Insurance Services
An Ascension Company

Summit America Insurance Services, Inc.
2180 South 1300 East, Suite 520
Salt Lake City, UT 84106
801-412-2626 Fax 801-412-2625

Mutual of Omaha

SEE REVERSE SIDE FOR FRAUD LANGUAGE

To Be Completed by Organization

Policy Number: T5MP-SAIC-5077
Organization/School Name: Williams College
Address: 22 Spring Street
Williamstown, MA 01267
Phone No. (413) 597 - 3511

Name of team/sport (if applicable) ____________

☐ Interscholastic/inter-collegiate ☐ Other ____________ (activity involved)

Date of event (if student-date school started): ____________
Organizational sponsored activity: ☐ Yes ☐ No Type of activity: ____________
If employed, was injury/sickness related to claimant's employment? ☐ Yes ☐ No

Type of Benefits Claimed

☐ Accident-Medical Date of Accident ____________
Hour a.m. p.m.

☐ Dental Location of accident ____________
Description of accident ____________

☐ Sickness-Medical Type of injury ____________
First treatment date ____________

☐ Loss of Time Dates claimed ____________

Dated: ____________ ____________
Signature of Organization Official & Title

To Be Completed By Claimant – Or By Parent/Legal Guardian If Claimant Is A Minor

Claimant's Name: ____________ ID Number M ____________
Age: ____________ ☐ Male ☐ Female
Date of Birth: ____________
Address of Parents, Guardian or Claimant: ____________ Home Phone No ( )

Name and address of Family Physician: ____________ Phone No ( )

Has treatment been completed? ☐ Yes ☐ No

Father, Guardian or Claimant's (if adult) Employer, Name and Address: ____________ Phone No ( )

Mother or Spouse's Employer, Name and Address: ____________ Phone No ( )

Name of all companies providing your insurance coverage of prepaid health plans.

Name of Company	**Address**	**Policy or Certificate No.**

☐ Individual
☐ Group (Eff. Date)
(See reverse side for important notice)

Are benefits due for this claim under these other insurance coverages? ☐ Yes ☐ No

I hereby certify that all the above information is true and complete.

Signature ____________ Date ____________