



NACDA Insurance
 A division of Summit America Insurance Services, LC
 2180 South 1300 East, Ste 520
 Salt Lake City, UT 84106



SEE REVERSE SIDE FOR FRAUD LANGUAGE

To Be Completed By Organization

Policy Number: _____
 Organization/School Name: _____
 Address: _____

Phone No. (_____) _____ - _____

Name of team/sport (if applicable): _____
 Interscholastic/intercollegiate 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 _____
 Sickness-Medical Description of accident _____
 Type of injury _____
 Loss of Time First treatment date _____
 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 or prepaid health plans.

Name of Company	Address	Policy of Certificate No.
_____	_____	_____ <input type="checkbox"/> Individual
_____	_____	_____ <input type="checkbox"/> Group (Eff. Date _____)

Are benefits due for this claim under these other insurance coverages? Yes No (See reverse side for important notice.)

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

Signature _____ Date _____