



MARKEL INSURANCE COMPANY

COMPLETE AND MAIL TO:

POMCO
P. O. Box 186
Syracuse, NY 13206-0186
(866) 834-4765

STATE STATUTES SPECIFY: "Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation."

Claim procedures and online access to our claim form are available from our website at:

www.markelmedical.com

CLAIM CANNOT BE PROCESSED WITHOUT THIS INFORMATION

Form with fields for COLLEGE (OR) UNIVERSITY, POLICY #, SOC. SEC. #, STUDENTS NAME, IF CLAIM FOR DEPENDENT, GIVE NAME AND RELATIONSHIP, STUDENT / DEPENDENT FULL ADDRESS (WHILE AT SCHOOL), FULL ADDRESS (HOME), STREET ADDRESS, CITY, STATE, ZIP, TELEPHONE.

- (1) Date of injury (or) beginning of sickness... When physician first consulted?
Type of illness (or) injury...
If pregnancy, please indicate your last menstrual period (LMP) date:
If injury, (a) How did accident occur?
(b) Where did accident occur?
(c) Were you practicing or playing any intercollegiate (between rival colleges) sport at the time of the accident?
(2) Were you treated by the Student Health Service?
Were you referred by the Student Health Service?
If "No," was the Student Health Service closed?
(3) Hospital: (Give name, address and date of confinement)
(4) Give names, addresses and telephone numbers of all attending physicians
(5) Give name, address and telephone number of usual family physician
(6) Have you suffered same or similar condition in the past?
(7) DO YOU HAVE OTHER INSURANCE WHICH COVERS THIS CONDITION, EITHER GROUP, INDIVIDUAL AUTOMOBILE, MEDICAL OR LIABILITY?
(8) Is condition due to injury or sickness arising out of your employment?

AUTHORIZATION REGARDING PAYMENT OF BENEFITS

For services rendered or to be rendered I hereby authorize MARKEL INSURANCE COMPANY or their representatives to pay benefits in connection with this accident or illness direct to the doctor, hospital or other rendering service. If receipted bills are submitted, the benefits are to be paid to:

AUTHORIZATION FOR RELEASE OF INFORMATION

I AUTHORIZE any physician, medical care provider, hospital, clinic, medical care facility, insurance company, government-sponsored health plan, or employer having information available as to diagnosis, treatment and prognosis with respect to any illness, injury, physical or mental condition, and/or treatment for me or my minor children now or in the past, to give to Markel Insurance Company (MIC) or its legal representative, any and all such information.

I UNDERSTAND the information obtained by the use of the Authorization will be used by MIC to determine eligibility for insurance and eligibility for benefits under any existing policy. Any information obtained will not be released by MIC to any person or organization EXCEPT as necessary in connection with the processing of this application, claim, or as may be otherwise lawfully required or as I may further authorize.

I KNOW that I may request to receive a copy of this Authorization.

I AGREE that a photographic copy of this Authorization shall be as valid as the original. I also AGREE this Authorization shall be valid for a period of two years from the date shown below. I may revoke this authorization at any time by written request to MIC.

I CERTIFY that the above information given by me in support of this claim is true and correct.

Claimant, Parent, or Authorized Representative's Signature: Date:

If Authorized Representative, Relationship to Patient or Legal Designation: Date:

To review our Privacy Policy, please go to www.Markelmedical.com

ATTENDING PHYSICIAN'S STATEMENT - HEALTH INSURANCE CLAIM ACCIDENT OR SICKNESS

PATIENT'S NAME AND ADDRESS _____	MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>	AGE _____
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- (1a) Diagnosis and Concurrent Conditions (If fracture or dislocation, describe nature and location): _____
- (b) If pregnancy, please indicate the patient's last menstrual period (LMP) date: _____
- (c) Is condition due to injury or sickness arising out of patient's employment? Yes No If "Yes," explain: _____
- (d) Describe any other disease or infirmity affecting present condition: _____
- (2a) When did symptoms first appear or accident happen? Date _____, 20____
- (b) When did patient first consult you for this condition? Date _____, 20____
- (c) Has patient ever had same or similar condition? Yes No If "Yes," state when and describe: _____
- (d) If patient referred by other doctor, give name and address of such doctor: Name: _____
Address: _____ City: _____ State: _____ Zip: _____
- (3a) Nature of surgical or obstetrical procedure, if any (describe fully): (Please give CPT Procedure Code) _____
- (b) Charge to patient for this procedure including postoperative care: Date performed _____, 20____ \$ _____
- (c) If performed in hospital, give name of hospital: _____ Inpatient Outpatient
- | | |
|--|---------------------------------------|
| (4a) Give dates of other (non-surgical) treatment, if any: _____ | (4c) CHARGE PER CALL |
| _____ | Office _____ \$ _____ |
| (b) If patient hospitalized, give confinement dates, name and address of hospital: _____ | Home _____ \$ _____ |
| _____ | Hospital _____ \$ _____ |
| _____ | Nursing Home _____ \$ _____ |
| | Total (non-surgical) charges \$ _____ |
- (5) What other services, if any did you provide patient? (Itemize, giving dates and fees): _____
- (6) Were registered private duty nurse (RN) services necessary? _____
- (7) Is patient still under your care for this condition? Yes No If "No," give date your services terminated: _____, 20____
- (8) Did you file this claim with any other Insurance Company? Yes No If "Yes," indicate name and address of company: _____

(ANSWER ALL QUESTIONS ABOVE, IN ADDITION TO THOSE BELOW, IF DENTISTRY.)

1. State exactly which teeth were involved in the accident and indicate them on chart:

DENTAL

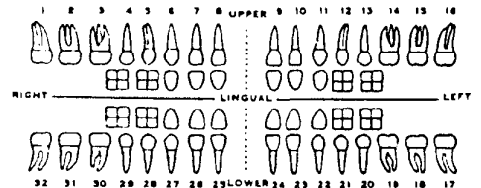
2. Describe exact nature of injury.

INJURY

3. Describe condition of injured teeth prior to accident:

Whole, Sound and Natural Filled Capped Artificial

4. Comments _____



REMARKS

DATE _____	SIGNATURE (Attending Physician: Please Print) _____	DEGREE _____
I.R.S., I.D., or S.S. # _____	TELEPHONE _____	
STREET ADDRESS _____	CITY _____	STATE _____
ZIP CODE _____		