

1. PLEASE FULLY COMPLETE THIS FORM
2. ATTACH ITEMIZED BILLS
3. MAIL TO 

KLAIS & COMPANY, INC.
 EMPLOYEE BENEFIT CONSULTANTS AND ADMINISTRATORS
 1867 WEST MARKET STREET
 AKRON, OHIO 44313-6977
 (330) 867-8443
 (800) 331-1096



Group Number:
 SH-449

Name of Policy Holder:
 Career Education Corporation

FAX: (330) 867-0827

ELECTRONIC TRANSMISSION # 34145

PART I – POLICYHOLDER’S REPORT

| | | | | |
|---|--|--|------|--|
| 1. SCHOOL NAME and BUSINESS UNIT NUMBER | | 2. SCHOOL ADDRESS | | |
| | | Street | City | State |
| | | | | Zip |
| 3. NAME OF INJURED STUDENT | | 4. SOCIAL SECURITY NUMBER | | 5. SEX |
| | | - - | | _F_ _M_ |
| | | | | 6. BIRTHDAY |
| | | | | __ / __ / __ |
| 7. ADDRESS OF INJURED STUDENT | | | | E-MAIL ADDRESS |
| Street | | | | |
| City | | | | |
| State | | | | |
| Zip | | | | |
| 8. IF STUDENT IS A DEPENDENT, PARENTS’ NAME, ADDRESS AND PHONE NUMBER (INCLUDE AREA CODE) | | | | |
| 9. DATE AND TIME OF ACCIDENT | | 10. PLACE WHERE ACCIDENT OCCURRED | | 11. WAS INJURED PERSON A PARTICIPANT, STAFF MEMBER, GUEST OR VOLUNTEER? |
| | | | | |
| 14. NATURE OF INJURY (INDICATE PART OF BODY INJURED - SUCH AS BROKEN ARM, SPRAINED ANKLE, ETC.) | | | | |
| | | | | |
| 15. DESCRIBE HOW ACCIDENT OCCURRED - GIVE ALL POSSIBLE DETAILS - MUST BE A BODILY INJURY DUE TO ACCIDENT | | | | |
| | | | | |

16. DID ACCIDENT OCCUR (CIRCLE YES OR NO) FOR EACH OF THE FOLLOWING:

| | | |
|--|-----|----|
| A. During a policyholder sponsored & supervised activity? | YES | NO |
| B. During programmed hours? | YES | NO |
| C. On activity premises? | YES | NO |
| D. While on the job (if applicable)? | YES | NO |
| E. While traveling directly and uninterruptedly to or from home and policyholder premises? | YES | NO |
| F. During intercollegiate/scholastic athletic practice? YES NO or competition? | YES | NO |

| | | |
|---|---|-----------------|
| 17. NAME OF EVENT OR ACTIVITY: | 18. NAME & TITLE OF SUPERVISOR | |
| | | |
| 19. SIGNATURE OF POLICYHOLDER REPRESENTATIVE | 20. TITLE | 21. DATE |
| | | |

PART II – OTHER INSURANCE STATEMENT

Do you/spouse/parent have medical/health care coverage through your employer or other source on you? YES NO
 If Yes, name of insurance company _____ Policy # _____

Is the Claimant enrolled as an individual, employee or dependent member of one of the following:
 Preferred Provider Organization (PPO), Health Maintenance Organization (HMO) or similar prepaid health care plan, or any other type of accident/health/sickness plan? YES NO
 If Yes, name of insurance company _____ Policy # _____

If your son/daughter has health care coverage as a dependent from your previous marriage as mandated in a divorce decree, please provide the following:
 Name of Insurance Company _____ Policy # _____

IF OTHER INSURANCE OR HEALTH CARE PLANS EXIST, PLEASE SUBMIT COPIES of their EXPLANATION OF BENEFITS along with your claim. IF NO OTHER INSURANCE or HEALTH PLAN EXISTS, PLEASE READ & SIGN BELOW.
 I agree that should it be determined at a later date there is insurance (or similar), to reimburse **KLAIS & COMPANY, INC.**, or the insurance company to the extent of any amount collectible.

| | | |
|---|----------------|-------------|
| SIGNATURE OF PARTICIPANT OR PARENT | WITNESS | DATE |
| | | |

AUTHORIZATION TO PAY BENEFITS TO PROVIDER

I authorize medical payments to physician or supplier for services described on any attached statements enclosed.

SIGNATURE _____ **DATE** _____

I hereby authorize any insurance company, hospital, physician or other person who has attended or examined the claimant to disclose when requested to do so, all information with respect to any injury, policy coverage, medical history, consultation, prescription or treatment, and copies of all hospital or medical records. A photo static copy of this authorization shall be considered as effective and valid as the original.

SIGNATURE _____ **DATE** _____