



P.O. Box 6947
Boise, ID 83707-0947
Phone 1-877-955-1559

Nationwide Life Insurance Company
Idaho State University

Health Benefit Claim Form

Insured Student

1. Student's Name	2. Date of Birth	3. Student's Address
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4. Complete if Accident/Injury: (Use the back of this page if additional room is needed.)

Original date of injury: _____

Where did the injury occur? _____

Details of injury: _____

MVA related? Yes or No If yes, a separate Lien Agreement letter will be mailed to you to complete and sign.

5. Complete if Sickness

When did symptoms begin? _____

Type of sickness: _____

Date patient first sought treatment: _____

Name of Doctor: _____

Have you had this condition before? _____

If yes show dates of prior treatment: _____

6. Is there other Medical Dental Coverage (other than listed above)?
 No Yes (If yes, please provide the following information.)

Name of insurance company: _____ Policyholder name: _____

Effective date of policy: _____ Termination date of policy: _____

If student is the policy holder is the other health plan: _____ Group Health _____ Individual Plan

7. Student Health Center Referral **To be completed by Health Center authorized personnel Only**

Date seen at Student Health Center _____

Diagnosis: _____ Referred to: _____

Authorized Signature _____

Important: This form must be completed and returned to the company within 90 days from the date of treatment accompanied by all bills incurred to that date. Please attach itemized bills

For your protection, State Law requires that the following appear on this form: "Any Person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

AUTHORIZATION: I hereby authorize Nationwide Life Insurance Company/AmeriBen, or its representative, to inspect or secure copies of case history records, laboratory reports, diagnosis, prognosis, x-rays, and any other data covering this and/or previous confinements and/or disabilities. A photostatic copy of this authorization shall be deemed as effective and valid as the original.

I hereby authorize Nationwide Life Insurance Company/AmeriBen to pay bills in connection with this claim directly to the Doctor, Hospital or Other Payee indicated above. I understand that I or my authorized representative is entitled to receive a copy of this authorization upon request.

SIGNATURE OF STUDENT: _____ **DATE:** _____