Aetna Student Health
PO Box 981106
El Paso, TX 79998
1-877-480-4161

PARTICIPANT ACCIDENT CLAIM FORM

INSTRUCTIONS

- ✓ **PLEASE FULLY COMPLETE THIS FORM**
- ✓ **FOR ACCIDENTAL DEATH CLAIMS INCLUDE DEATH CERTIFICARE. FOR DISMEMBERMENT CLAIMS INCLUDE MEDICAL RECORS/PROOF OF LOSS**

FORM SUBMISSION OPTIONS

Paper Form – Mail to:
Aetna Student Health
PO Box 981106
El Paso, TX 79998

Fax to:
859-455-8650

PART I: MEMBERS REPORT

1. Members Name (Injured Person or Deceased)	2. Member ID #	3. Gender	4. Date of Birth	5. E-Mail

6. Member's Address:

7. Member's Best Contact Phone Number Including Area Code (If applicable)

8. If Applicable, Parent's Name, Address, and Best Contact Phone Number (Include Area Code):

9. Date and Time of Accident:

10. Place where accident occurred:

11. Describe how accident occurred – (Attach additional pages if necessary)

12. Name of Member's Personal Representative:

13. Signature of Member's Personal Representative	14. Relationship to Member	15. Date

PART II: AUTHORIZATION

I verify that all information contained in this form is true, correct, and complete to the best of my knowledge. I authorize any licensed doctor, practitioner of the healing arts, hospital, clinic, health-related facility, pharmacy, government agency, insurance company, group policyholder, employee or benefit plan administrator having information as to the care, advice, treatment, diagnosis or prognosis of any physical or mental condition of the insured named below, to provide this information to Aetna Life Insurance Company. I understand that I have the right to receive a copy of this authorization upon request. A copy of this shall be as valid as the original. This authorization is valid for twelve months from the date signed. I further certify I have read and signed the Fraud Warning statement listed on the next page of this form.

SIGNATURE OF MEMBER, MEMBERS'PERSONAL REPRESENTATIVE: **DATE:**

PART III: ATTESTATION FOR DECEASED MEMBERS

By signing this form, you are certifying you are the member's personal representative and have the rights and authority to collect the benefits on behalf of the member and/or their estate.

SIGNATURE OF MEMBER, MEMBER'S PERSONAL REPRESTATIVE **Date:**

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FRAUD STATEMENTS

IMPORTANT NOTICE

Applicable in New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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 subjects such person to criminal and civil penalties not to exceed five thousand dollars and the stated value of the claim for each such violation.