

UVSC CLAIM FORM / INJURY ACCIDENT REPORT

Mail To: Utah Valley State College t c/o Linda Moore, Insurance t MS 200, 800 West University Parkway t Orem, UT 84058 t Phone: (801) 863-8066

PLEASE COMPLETE ALL INFORMATION

INJURED PERSON	Name (last, first middle)		Date of birth	UVSC police # (if known)	Health / Safety # (if known)	
	Address (including zip code)		Social Security Number	Work phone	Home phone	
			Employment status (circle one) Full / Part-time	Sex (circle one) M / F	Marital status (circle one) Single / Married	
	Occupation / Job Title			Status Current UVSC student <input type="checkbox"/> UVSC employee <input type="checkbox"/> Visitor to UVSC <input type="checkbox"/>		
<i>UVSC employees must contact a Workman's Compensation Representative in Human Resources as soon as possible! (801) 863-8207 For any accident or injury, contact Student Accident Insurance @ (801) 863-8066, the Department of Health & Safety @ (801) 863-7977, or Campus Police @ (801) 863-8187</i>						
ACCIDENT / INJURY INFORMATION	What was the date the accident / injury occurred?		What was the time the accident / injury occurred?	What was the date UVSC was notified and who was contacted?		
	Were you injured in a UVSC class? Yes <input type="checkbox"/> No <input type="checkbox"/> If so, please indicate teacher and class?		Were you injured on campus? Yes <input type="checkbox"/> No <input type="checkbox"/> Or in a UVSC sponsored activity? Yes <input type="checkbox"/> No <input type="checkbox"/>	Were you injured in a physical education activity in a class, intramurals, club sports, or an intercollegiate sport? Yes <input type="checkbox"/> No <input type="checkbox"/> Indicate activity / sport?		
	What was the address where accident occurred?			What was the department or location where the accident occurred		
	What type of injury did you sustain?			What part of your body was injured?		
	Who were the witnesses who saw your accident happen?			What are the witnesses' phone numbers		
	Were safeguards or safety equipment provided? Yes <input type="checkbox"/> No <input type="checkbox"/>		Were they used? Yes <input type="checkbox"/> No <input type="checkbox"/>		Has Risk Management been contacted? (Phone: (801) 863-7977) Yes <input type="checkbox"/> No <input type="checkbox"/>	
	What was the specific activity you were engaged in when the accident occurred?		List all equipment, materials, or chemicals involved in the accident:		Was the incidence caused by any person our outside company besides UVSC? Yes <input type="checkbox"/> No <input type="checkbox"/> If so, list:	
	What was the date of your first treatment?	Was this a work-related injury? Yes <input type="checkbox"/> No <input type="checkbox"/>	Was an ambulance needed? Yes <input type="checkbox"/> No <input type="checkbox"/>	Was treatment refused? Yes <input type="checkbox"/> No <input type="checkbox"/>	Were you hospitalized? Yes <input type="checkbox"/> No <input type="checkbox"/>	
	In your own words, please give a full description of how and when your accident / injury occurred (include witnesses, circumstances, objects, substances, etc. THIS FIELD MUST BE COMPLETED , use the back of this form if necessary):					
	Who was the attending first responder?			Who was the attending emergency medical provider?		
INSURANCE	What is the name of your primary insurance carrier?			What is the name of the person who your primary insurance is listed under?		
	What is your primary insurance carrier's address? (Include city, state, and zip code)			What is the phone number of your insurance company?		
	Did you have a primary insurance carrier (as an insured or dependent)?			If you were involved in any type of athletics, did you have the REQUIRED primary insurance coverage?		
	What is your group number?	What is your policy number?	Have you filed a claim for this injury with your primary insurance carrier? Yes <input type="checkbox"/> No <input type="checkbox"/>	Did you receive medical services by a provider authorized by your insurance carrier? Yes <input type="checkbox"/> No <input type="checkbox"/>		
RELEASE	<i>To any medical provider, medical care facility, government-sponsored health plan, or employer: I permit (while my claim is pending) the release of any medical information about me to the College and its representatives. This applies to all information about the diagnosis, treatment, or prognosis of any illness or injury I now have or have had in the past. The College will use this information to find out if my claim is eligible. A copy of this authorization (one of which will be given to me) will be as valid as this one. I certify that the above information given by me is true and correct.</i>					
	Patient's signature required:			Date:		
	Signature of College Official: _____ Title: _____			Date: _____		

This claim form must be completed in order to apply for UVSC Student Self-Funded Accident Insurance, with the understanding UVSC pays as a secondary insurance carrier. To submit a claim, please submit this form along with itemized bills from all providers and an Explanation of Benefits from your primary insurance carrier indicating what they paid to each provider. Remember, insurance fraud is a crime and is punishable by law.