CLM # D._____ H._____ P._____

PLAN	PAY

DATE PREM. PD. _____
AMOUNT PD. _____
DATE PD. OR DECL. _____

THIS SPACE FOR COMPANY USE ONLY

NAME OF SCHOOL _____
ADDRESS _____
POLICY NO. 214-125-016-G

IMPORTANT!
THIS INFORMATION MUST BE GIVEN OR CLAIM WILL BE RETURNED

First Agency, Inc.
5071 West H Avenue
Kalamazoo, MI 49009-8501
Phone (269) 381-6630 - Fax (269) 381-3055

ASSIGNMENT OF BENEFITS:

Dr._____ Hosp. _____ Other: _____

Address	Address	Address
City State Zip	City State Zip	City State Zip
Taxpayer I.D. or S.S. # Acct. #	Taxpayer I.D. or S.S. # Acct. #	Taxpayer I.D. or S.S. # Acct. #

I hereby authorize The Guarantee Trust Life Insurance Company to pay bills in connection with this accident directly to the Doctor, Hospital or Other Payee Indicated.

DATE_____ **SIGNATURE OF PARENT OR GUARDIAN**_____
(Claimant if an ADULT)

SCHOOL OFFICIAL TO COMPLETE — (PLEASE PRINT, PARENT MUST COMPLETE IF 24-HOUR COVERAGE CLAIM IS INVOLVED)
SOCIAL SECURITY NUMBER MUST BE SHOWN OR CLAIM WILL BE RETURNED

1. Claimant's FULL NAME _____ S.S. #_____ Date of Birth ____/____/____ (M/D/Y)
2. Claimant's Address _____ (Street or RFD) (City) (State) (Zip)
3. Page and Line Number on Lists of Insured: Page No. _____ Line No. _____ Grade _____
4. Date of Accident/Sickness: _____ 20____ Hour_____ (Check One) A.M. ____ P.M. ____
5. Description of Accident/Sicknesss: (A) How and where did it occur? _____
   (if more space is needed, attach separate sheet)
   (B) Nature of Injury/Sickness:_____ Part of Body: _____ left or right ____
6. Description of Activity (What was Claimant doing at time of Accident/Sickness?) _____
   If Athletics — name sport _____ Check one: ❑ Intramural ❑ Interscholastic ❑ Other
7. On date of accident what time did school start for this student? _____
   What time was student dismissed from school? _____
8. Has previous claim been filed for this accident? ❑ Yes ❑ No
9. A. Name of School Authority supervising Activity _____
   B. Was Supervisor a witness? _____ If not, when was Accident first reported to School Authority? _____

I certify that the above information is correct to the best of my knowledge and belief.
Date of this report _____ Signature of School Official _____ Title _____

PARENT TO COMPLETE (or Claimant, if an Adult) IN ORDER FOR CLAIM TO BE PROCESSED

10. Do you have other insurance which covers this condition, either group, individual, automobile medical or liability? Yes ❑ No ❑ If yes, give name of company_____
    Policy No. _____
11. Parents' Name _____ Father _____ Mother _____
    Employer's Name _____ _____ _____
    Employer's Address _____ _____ _____

FOR AUTHORIZATION SIGNATURE
PLEASE SEE OTHER SIDE

FIRST AGENCY, INC.
GUARANTEE TRUST LIFE INSURANCE COMPANY
5071 WEST H AVENUE, KALAMAZOO, MI. 49009
1-269-381-6630

AUTHORIZATION

To Permit Use and Disclosure of Health Information

This Authorization was prepared by FAI for purposes of obtaining information necessary to process a claim for benefits.

Upon presentation of the original or a photocopy of this signed Authorization, I authorize, without restriction (except psychotherapy notes), any licensed physician, medical professional, hospital or other medical-care institution, insurance support organization, pharmacy, governmental agency, insurance company, group policyholder, employer or benefit plan administrator to provide FIRST AGENCY, INC. (FAI) or an agent, attorney, consumer reporting agency or independent administrator, acting on it's behalf, all information concerning advice, care or treatment provided the patient, employee or deceased named below, including all information relating to, mental illness, use of drugs or use of alcohol. This Authorization also includes any information provided to any affiliated insurance company on previous applications. If this Authorization is for someone other than myself, that individual and my authority to act on their behalf is explained below.

I understand that I have the right to revoke this Authorization, in writing, at any time by sending written notification to my agent or to us at the above address. I understand that a revocation will not be effective to the extent we have relied on the use or disclosure of the protected health information or if my Authorization was obtained as a condition to determine my eligibility for benefits. Revocation requests must be sent in writing to the attention of the Claim Department Manager.

I understand that FIRST AGENCY, INC. may condition payment of a claim upon my signing this Authorization, if the disclosure of information is necessary to determine the level or validity of the claim payment. I also understand once information is disclosed to us pursuant to this Authorization, the information will remain protected by FAI in accordance with federal or state law.

This Authorization is valid from the date signed for the duration of the claim.

_____

(Print Please) Name of Patient

_____

Signature of Patient and Date

_____

(Please Print) Name of Authorized Representative, or Next of Kin

_____

Relationship of Authorized Representative or Next of Kin to Patient

_____

Signature of Authorized Representative or Next of Kin and Date