SUMMIT AMERICA
Insurance Services
7400 College Boulevard, Suite 100
Overland Park, KS 66210
913-327-0200 • 800-955-1991

MUTUAL of OMAHA

SEE REVERSE SIDE FOR FRAUD LANGUAGE

To Be Completed By Organization

Policy Number: _____
Organization/School Name: _____
Address: _____
_____
Phone No. (_____) _____-_____

Name of team/sport (if applicable): _____
☐ Interscholastic/intercollegiate ☐ Other _____ (activity involved)

Date of event (if student-date school started): _____

Organizational sponsored activity: ☐ Yes ☐ No Type of activity: _____

If employed, was injury/sickness related to claimant's employment? ☐ Yes ☐ No

Type of Benefits Claimed

☐ Accident-Medical
☐ Dental
☐ Sickness-Medical
☐ Loss of Time

Date of Accident _____ ☐ Hour ☐ a.m. ☐ p.m.
Location of accident _____
Description of accident _____
Type of injury or illness _____
First treatment date _____
Dates claimed _____

Dated: _____ _____
Signature of Organization Official & Title

To Be Completed By Claimant — Or By Parent/Legal Guardian If Claimant Is A Minor

Claimant's Name: _____ ID # M _____

Age: _____ ☐ Male ☐ Female

Address of
Parents, Guardian or Claimant: _____
_____
_____
Home
Phone No (_____) _____-_____

Name and address of Family Physician: _____
_____
Phone No (_____) _____-_____

Has treatment been completed? ☐ Yes ☐ No

Father, Guardian or Claimant's (if adult)
Employer, Name and Address: _____
_____
Phone No (_____) _____-_____

Mother or
Spouse's Employer, Name and Address: _____
_____
Phone No (_____) _____-_____

Name of all companies providing your insurance coverage or prepaid health plans.

Name of Company	Address	Policy of Certificate No.	
			☐ Individual
			☐ Group (Eff. Date _____)

Are benefits due for this claim under these other insurance coverages? ☐ Yes ☐ No
(See reverse side for important notice.)

I hereby certify that all above information is true and complete.

Signature _____ Date _____