



3320 West Market Street, Suite 100
Fairlawn, OH 44333-3306
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University of Cincinnati Bloodborne Pathogen Claim Form

TO BE COMPLETED BY STUDENT

1. School Name: University of Cincinnati Group No: US096552
2. Insured Person: _____ UCID#: _____
3. Local Address: _____
4. Home Address: _____
5. Date of Birth: ___/___/___ Local Phone: () _____ Home Phone: () _____
6. Is this claim the result of an accident: ___ Yes ___ No If "yes", give date of accident: ___/___/___ Time of Accident: _____
7. Where did the accident occur? _____
Provide detailed description of the accident and how it occurred. _____

8. Is patient covered for benefits by any other Group Health, Employer, Union, Welfare Plan or Parent Health Plan? ___ Yes ___ No

If answered "yes", please complete the following:

Coverage provided through:

Name of Person _____ Relationship _____
 Address _____ Address _____
 Telephone () _____ Telephone () _____ Policy # _____

Please include a photocopy of other plan identification card, if available.

9. I hereby authorize any Insurance Company, Organization, Employer, Hospital, Physician, Surgeon or Pharmacist to release any information requested with respect to this claim.

It is unlawful to knowingly provide false, incomplete or misleading facts or information regarding a claim for the purpose of defrauding or attempting to defraud to receive benefits. Penalties may include imprisonment, fines, denial of benefits and/or civil damages. For your protection, California law requires the following to 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.

Signature of Insured _____ Date _____ 20____

Signature of College Official _____ Title _____ Date _____ 20____

I hereby certify that the statements made are correct to the best of my knowledge and believe that the above named claimant was insured hereunder at the time of the accident, and that the above injury was sustained while participating in official activities under adequate organizational supervision on _____.

Date of Accident _____

Mail both this form and the claim to:

HealthSmart Benefit Solutions, 3320 West Market Street, Suite 100, Fairlawn, OH 44333