

# KLAVIS & COMPANY, INC.

## EMPLOYEE BENEFIT CONSULTANTS AND ADMINISTRATORS

### University of Cincinnati Blood Borne Pathogen Claim Form

**TO BE COMPLETED BY STUDENT**

1. School Name: \_\_\_\_\_ Group #: \_\_\_\_\_
2. Insured Person: \_\_\_\_\_ SSN: \_\_\_\_\_
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:**

**Klais & Company Inc., 1867 West Market Street, Akron, OH 44313-6977**

**Phone: 1-800-331-1096 Fax: 1-330-867-0827**