

1. COMPLETE THIS FORM
2. ATTACH ALL ITEMIZED BILLS
3. MAIL TO →

**LEFEBVRE INSURANCE**  
**850 FRANKLIN STREET**  
**WRENTHAM, MA 02093**  
**(800) 451-9668**

**ACCIDENT CLAIM FORM**  
Please Print or Type

IF PART A, PART B AND PART C ARE NOT COMPLETED IN FULL THIS CLAIM WILL NOT BE PROCESSED AND WILL BE RETURNED

## PART A - SCHOOL

(1) Name of School:				(2) Name of School District:				
(3) Address of School: (Street)		(City)	(State)	(Zip)	(4) Area-Code + Telephone # ( )		(5) Date of Injury Mo / Day / Yr	
(6) Name of Insured Person:		(7) Date of Birth Mo / Day / Yr		(8) Social Security # <u>Required</u> - -		(9) Age	(10) Grade	(11) Male <input type="checkbox"/> Female <input type="checkbox"/>
(12) Injury Occurred: Practice <input type="checkbox"/> Game <input type="checkbox"/> P.E. <input type="checkbox"/> Travel <input type="checkbox"/> Classroom <input type="checkbox"/> At Home <input type="checkbox"/> Other <input type="checkbox"/>				(13) Type of Sport:				
(14) DETAILS ON HOW the injury occurred. NOTE: If your school uses an accident report form, please attach a copy of the report.								
(15) What part of the body was injured:				(15a) Time of injury: _____ am _____ pm				
(16) At the time of the accident, was the injured person involved in an activity under the jurisdiction of the policyholder? YES <input type="checkbox"/> NO <input type="checkbox"/>								
(17) Name of Supervisor (If different from organization official)			(18a) Name of Organization			(18b) Was he/she a witness to accident? YES <input type="checkbox"/> NO <input type="checkbox"/>		
(19) Signature of School or organization official				(20) Title of Official		(21) Date Signed Mo / Day / Yr		

**NOTE: THE STUDENT'S SOCIAL SECURITY NUMBER MUST BE USED ON ALL CLAIM FORMS**

## PART B - PARENT OR GUARDIAN STATEMENT

(1) Name of Living Parent(s) or Guardian(s)		(2) Social Security # - -	(3) Relationship: Father <input type="checkbox"/> Mother <input type="checkbox"/> Guardian <input type="checkbox"/> Other <input type="checkbox"/>	
(4) Address (Number) Street (Lot or Apt. No.)		(5) City	(6) State	(7) Zip Code
(8) Area Code + Telephone # ( )		(9) Father's work telephone ( ) _____ Mother's work telephone ( ) _____		
(10) Occupation of Father or Male Guardian		(11) Place of Employment		(12) Address of Employer
(13) Occupation of Mother or Female Guardian		(14) Place of Employment		(15) Address of Employer
(16) Do you have any other health and/or accident insurance plan (other than this plan)? Father: YES <input type="checkbox"/> NO <input type="checkbox"/> Mother: YES <input type="checkbox"/> NO <input type="checkbox"/> Guardian: YES <input type="checkbox"/> NO <input type="checkbox"/>				
(17) Is the injured person covered by other health and/or accident insurance plan? YES <input type="checkbox"/> NO <input type="checkbox"/>			If Yes, Effective Date Mo / Day / Yr	
(18) Name of other health and accident insurance company			Employer: YES <input type="checkbox"/> NO <input type="checkbox"/>	
(19) Address of Insurance company			(20) Policy Number	
<small>I hereby authorize any insurance company, hospital, physician, employer or other person who has attended or examined the claimant to disclose when requested to do so, all information with respect to any injury, policy coverages, medical history, consultation, prescription or treatment, and copies of all hospital or medical records and itemized bills. A photostatic copy of this authorization shall be considered as effective and valid as the original. I swear that the above information is true and correct to the best of my knowledge and further understand that it is a criminal offense to knowingly file a statement of claim containing false or misleading information or to willfully conceal information material thereto with the intent to defraud an insurance company.</small>				
(Date)		(Signature of Responsible Party or Student if 18 years old)		

AUTHORIZATION TO PAY BENEFITS TO PROVIDER: I authorize payment of Medical payments to Physician or Supplier for Services described on the reverse side and/or attached.

(Date)

(Signature of Responsible Party)

