YMCA CLAIM FORM

Training/Internship Program

Name of insured ____ Plan ID Number ____________ Social Security # ___________________

Permanent Address – Home____

Parent or guardian if claimant is under 21____

Name of camp or organization____

Address, if other than above – U.S.A.____

Date of illness or accident _____________________________________ Name of illness or injury____

If illness, have you had it before? _________________________________ When? Date of last medical treatment ________________________________

If accident, how did it happen? ____

If accident, is it job related? Yes______ No_____ If yes, is coverage available under your employer's Worker's Compensation insurance? ______________

If no, your employer must enclose a letter of denial from his or her Worker's Compensation insurance company so that we may process the claim.

Check should be sent to: □ Doctor □ Hospital □ Claimant □ Other

Name and address of physician____

If payment is to other than provider (Doctor or Hospital) attach proof of payment.

PHYSICIAN, SURGEON OR HOSPITAL AUTHORIZATION

I hereby authorize any hospital, physician, or other person who has attended me or examined me, to furnish to Nationwide Insurance or its representative, any and all information with respect to any illness or injury, medical history, consultation, prescriptions or treatment, and copies of all hospital or medical records. A photostatic copy of this authorization shall be considered as effective and valid as the original.

Date__________________________________ Signature____