WESTERN ILLINOIS UNIVERSITY

Western Illinois University Student Claim Form

If you need assistance completing this form, please contact the Student Insurance Office.
Please return completed form to:

Student Health Insurance Staff
#1 University Circle
Lower Level / Beu Health Center
Macomb, IL 61455
PH: 309-298-1882
Fax: 309-298-2363
TT#: 309-298-1856 (For The Hearing Impaired)

1. Name of Student:______________________________ SS#:________________

   Address:____

2. When did symptoms first appear or accident happened?________________________

3. What is the date of the medical emergency?______________________________

4. What is the injury or sickness?_______________________________________

5. If this is for an injury, describe how and where accident occurred, give complete details:

6. Did injury occur while working?______________________________________

7. If injured during practice or play of sports, what type of sport was involved? (check one):
   ❑ Intramural ❑ Interscholastic ❑ Other:______________________________

8. Name and address of doctor seen for this claim:____________________________

   ____

9. Do you have other insurance besides WIU Student Insurance that would cover these bills?
   ❑ Yes ❑ No

CLAIMS MUST BE SUBMITTED WITHIN 12 MONTHS FROM THE DATE OF SERVICE TO BE CONSIDERED UNDER THIS PLAN.

Upon presentation of the original or photocopy of this signed authorization, I authorize any medical professional, hospital, clinic or other medical or medically related facility, government agency or other person or firm to provide information including copies of records concerning advice, care or treatment provided to me and/or my dependents including, without limitation, information related to mental illness, use of drugs or alcohol to Western Illinois University Student Insurance representatives or HCH Administration representatives involved in evaluating, determining or administering claims for insurance benefits for me and/or my dependents. I understand that I or any authorized representative will receive a copy of this authorization upon request.

This authorization is valid from the date signed through the term of coverage of the policy or during the period to process the claims.

Signature:______________________________________ Date:________________

IMPORTANT: PLEASE ATTACH ALL ITEMIZED BILLS