P. O. Box 809025, Dallas, TX
75380-9025
Phone: 1-866-589-1053

University of Cincinnati Main Campus
Bloodborne Pathogen Claim Form

TO BE COMPLETED BY STUDENT

1. School Name: **University of Cincinnati Main Campus** SR ID#: _____
2. Insured Person: _____
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.

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

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

The Claim Form along with any other documentation can be submitted using one of the following methods:

Mail: UnitedHealthcare StudentResources, P. O. Box 809025, Dallas, TX 75380-9025 (This is listed on your ID Card)
Email: A scanned copy of the completed form to: *UnitedHealthcare* **Online:** Upload completed form via *MyAccount*