National Union Fire Insurance Company of Pittsburgh, Pa.

COVERAGE VERIFIED

MAIL TO:
Pearce Administration
Post Office Box 2436
Florence, South Carolina 29503
1-888-722-1668

SPECIAL NOTICE:Any person who knowingly presents a false or fradulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

TECHNICAL COLLEGE CLAIM FORM

COMPLETE IN DETAIL TO INSURE PROMPT HANDLING

*_PLEASE PRINT ALL INFORMATION_*
THIS SIDE MUST BE COMPLETED AND SIGNED

NAME OF SCHOOL	POLICY NUMBER CH00000841	BIRTH DATE
INSURED'S NAME (Last) (First) (M.I.)	INSURED'S SOCIAL SECURITY NO.	TELEPHONE NO.
PRESENT ADDRESS (No. & Street) (City/Town) (State) (zip + 4)		
PRESENT ADDRESS (No. & Street) (City/Town) (State) (zip + 4)		
If Claim for dependent give DEPENDENT'S NAME	RELATIONSHIP TO INSURED	BIRTH DATE

MUST BE COMPLETED Other Insurance

Are you covered by any hospital and/or medical plan? ❑ Yes ❑ No
Are you a dependent on this plan? ❑ Yes ❑ No
If YES, please check one: ❑ Group ❑ Individual ❑ Automobile/Medical
If YES, also indicate name and policy number of Insurance Company:

NAME OF INSURED _____ POLICY/GROUP# _____ I.D.# _____ COMPANY _____

Have you filed a claim with the above company? ❑ Yes ❑ No
Send copies of Explanation of Benefits showing benefits paid and/or benefits denied to Company at the address above.
Name and Address of Employer of:
❑ Insured, if employed _____
❑ Spouse, if insured is married _____

1. Date of Accident or sickness		Date of First Treatment
2. Nature of sickness or injury		
3. If injury, describe how and when the accident occurred and indicate if work-related.		
*4. If injured, in play or practice or sport, indicate which sport.		Check One: ❑ Intramural ❑ Intercollegiate ❑ Other
5. Have you previously been troubled with this condition?	❑ Yes ❑ No Date , 20	
6. Give name of all other physicians consulted.		
7. Hospitalized? If so, where and what dates?	Where?	From: , 20 To: , 20
8. Health Care referral? (If required)	❑ Yes If yes, attach referral to claims form. ❑ No If no, please explain:	

PAYMENT WILL BE PAID TO THE PROVIDERS OF SERVICE (Hospital, Physician and others), UNLESS A PAID RECEIPT OR STATEMENT ACCOMPANIES THE BILL AT THE TIME CLAIM IS SUBMITTED.
*IMPORTANT: ALL INTERCOLLEGIATE SPORTS CLAIMS MUST BE SIGNED BY AN AUTHORIZED OFFICIAL.
I hereby certify that the above injury was sustained while participating in official activities under adequate organizational supervision. _____

Signature of College Official _____ Title _____ Date _____

TO ANY MEDICAL CARE PROVIDER, MEDICAL CARE FACILITY, INSURER, GOVERNMENT-SPONSORED HEALTH PLAN, or EMPLOYER: I permit (while my claim is pending) the release of any medical information about me to the Company and its representatives. The Company's representatives include reinsuring companies and other persons or groups performing business or legal services relating to my claim. This applies to all information about the diagnosis, treatment, or prognosis of any illness or injury I now have or have had in the past. The Company will use this information to find out if my claim is eligible. A copy of this authorization (one of which will be given to me by the Company upon my request) will be as valid as this one.

I certify that the above information given to me in support of this claim is true and correct.

Patient's or Authorized Representative's Signature _____ Date _____

If Authorized Representative, relationship to patient _____

(No. & Street) (City/Town) (State) (Zip+4)

ITEMIZED BILLS FOR MEDICAL EXPENSES MUST BE ATTACHED

PART II — ATTENDING PHYSICIAN'S STATEMENT

AUTHORIZATION: I hereby authorize the Company, or the designated claims administrator, to inspect or secure copies of case history records, laboratory reports, diagnoses, prognoses, and any other date covering this or other confinements and disabilities.

DOCTOR, PLEASE SIGN: _____ Date _____

EACH DOCTOR'S BILL ATTACHED MUST BEAR THE DOCTOR'S I.D. OR SOCIAL SECURITY NUMBER.

1. Nature of sickness or injury. Describe any complications.	
2. If fracture or dislocation, state whether reduced or immobilized. If fracture of long bones, state whether fracture is through shaft or extremity. Was it confirmed by X-ray?	☐ Yes ☐ No
3. When did symptoms first appear or accident happen?	Date
4. When did patient first consult you for this condition?	Date
5. Has patient ever had same or similar condtion? If yes, state when and describe.	☐ Yes ☐ No Date
6. Describe any other disease or infirmity affecting present condition.	
7. Nature of any surgical or obstetrical procedure. Describe fully. Include CPT Code. Where and when performed?	Date If in hospital: ☐ In-patient ☐ Out-patient
8. Give dates of treatment.	
9. Is condition a result of or in any way connected with pregnancy?	☐ Yes ☐ No If yes, inception date of pregnancy:
10. Is patient still under your care for this condition? If discharged, give date.	☐ Yes ☐ No Discharge date
11. If patient hospitalized, give name and address of hospital.	Hospital _____ Address _____ Admission date Discharge date
12. Did you file this claim with any other Insurance Company? If yes, indicate name and address of Company.	☐ Yes ☐ No Name _____ Address

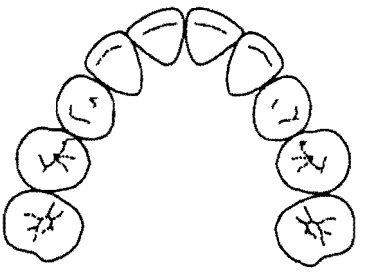
SIGNED _____ DEGREE _____ DATE _____

SOCIAL SECURITY NO. _____ THIS MUST BE INCLUDED! PHONE NUMBER _____

ADDRESS
(No. & Street) (City / Town) (State) (Zip + 4)

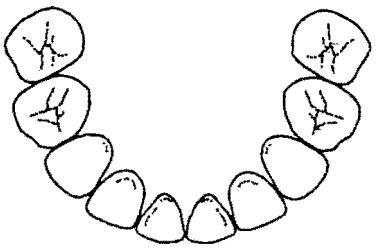
IF DENTISTRY, ANSWER ALL QUESTIONS BELOW IN ADDITION TO THOSE ABOVE.

1. State exactly which teeth were involved in the accident and indicate them on chart.



2. Describe exact nature of injury.

3. Describe condition of injured teeth prior to accident:
   ☐ Whole, sound and natural
   ☐ Filled ☐ Capped ☐ Artificial



4. Comments:

Beech Street Corporation

IMPORTANT: This form MUST be completed and returned WITHIN 90 DAYS from the date of treatment accompanied by all bills incurred to that date.