

Institution: UW-Milwaukee

Send Claims to the following:

Type of Camp/Clinic _____

Taryn Cistrunk
AON Risk Services Inc. of Wisconsin
330 E. Kilbourn Ave, Suite 450
Milwaukee, WI 53202-3179

Location Code: B

ACCIDENT CLAIM
(To Be Completed By the Injured Person)

FULL NAME (INJURED PERSON)			SOCIAL SECURITY NUMBER		
STREET ADDRESS			TELEPHONE NUMBER		
CITY OR TOWN, STATE, ZIP			AGE		
POLICY HOLDER'S NAME Board of Regents of the University of Wisconsin System			PHYSICIAN'S OR SURGEON'S NAME		
STREET ADDRESS PO Box 8010			STREET ADDRESS		
CITY OR TOWN, STATE, ZIP Madison, WI 53708			CITY OR TOWN, STATE, ZIP		
POLICY NUMBER 64044915			TELEPHONE NUMBER		
WHEN WERE YOU INJURED?	DATE	TIME AM/PM	IF HOSPITALIZED, NAME OF HOSPITAL		
WHEN DID YOU CEASE WORK?	DATE		STREET ADDRESS		
IF TOTALLY DISABLED, GIVE DATES	FROM	TO	CITY OR TOWN, STATE, ZIP		
WHEN DID OR WILL YOU RESUME ANY PART OF YOUR WORK?	DATE		HOSPITAL CONFINEMENT DATES	FROM	TO
DESCRIBE INJURIES					
DESCRIBE FULLY HOW AND WHERE ACCIDENT OCCURRED (Attach Separate Sheet if Necessary)					
I hereby authorize any hospital, physician, or other person who has attended me or examined me to furnish to the following Company, or their representatives, 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.					
Company: <u>Chubb Insurance Group by AON Risk Services Inc., of Wisconsin</u>					
Signature _____ Date _____					

Updated 6/11/02

(complete both sides of form)

PHYSICIAN'S REPORT
(To Be Completed By The Attending Physician)

Policy Holder's Name: Board of Regents of the University of Wisconsin System		Policy No. 6404-49-15		
1. PATIENT'S NAME:				
2. NATURE OF INJURY (DESCRIBE COMPLICATIONS, IF ANY)				
3. DESCRIBE ANY PRE-EXISTING CONDITION OR OTHER DISEASE OR INFIRMITY WHICH MAY OR MAY NOT AFFECT PRESENT CONDITION.				
	OFFICE			
4. GIVE DATES OF TREATMENTS	HOME			
	HOSPITAL			
5. IS YOUR PATIENT DISABLED?	<input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES <input type="checkbox"/> TOTAL <input type="checkbox"/> PARTIAL DATE:	ABLE TO WORK ON: DATE:	RESUMED WORK ON: DATE:
6. FACTORS PRESENT PROLONGING DISABILITY				
7. IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION?	<input type="checkbox"/> YES <input type="checkbox"/> NO	CONTEMPLATE DISCHARGE DATE:	IF DISCHARGED, GIVE DATE:	
8. AMOUNT OF YOUR BILL FOR SERVICES TO DATE:				
PHYSICIAN'S SIGNATURE _____ DATE _____				
STREET ADDRESS _____				
CITY OR TOWN _____ STATE _____ ZIP _____				
TELEPHONE NUMBER (_____) _____ - _____				

(complete both sides of form)