Equitable Adjusting & Service Company

Member of Moylan's Inc. Companies
207 JULALE CENTER, 424 WEST O'BRIEN DR
HAGATNA, GUAM 96910

Present Address _____ Postcode _____

Telephone # _____ E-mail: _____

Home Address _____ Postcode _____

Home country _____

Have you been covered (as an insured or dependent) by any other Hospital or medical plan during the past 12 months? YES / NO

Medical Plan Name:: _____ Policy # _____

TO BE COMPLETED IN CASE OF AN ACCIDENT (use additional paper if needed for explanations)

1.a. Name of person who is injured

1.b. Date of birth _____ 1.c. Nationality _____

1.d. Place of accident _____ 1.e. Date of accident _____

1.f. Time of accident _____

2. Precise details of accident _____

_____

_____

_____

Was the injury due to practice or play of a sport? ? - YES / NO

Which Sport?_____ Intercollegiate Intramural Club Other

Is Condition Work Related ? - YES / NO

Is condition due to an Auto Accident ? - YES / NO
(if yes - please attach policy information of all Autos involved)

Has the accident been reported to the police or other local authority ? - YES / NO

3.a. If yes, please enclose police report.
b. If not, state the reason why _____

_____

_____

_____

_____

_____

STUDENT INSURANCE PERSONAL ACCIDENT CLAIM FORM

was a third party involve? - YES / NO

4.a. If yes, are they to be held responsible for the accident? Please give reason why

5.a. What is the nature of the injury?

5.b. On which date and at what time was the first medical assistance provided?

5.c. Name and address of the doctor of facility who provided the first medical assistance

5.d. Were you treated the Student Health Service Center? YES / NO

5.e. If not, please explain why

5.f. Name and address of the subsequent doctor/s of facility who provided medical assistance

5.g Name and address of hospital in case of hospitalization

DEATH CLAIM

Date of death | | | | | | | | Place of death

I declare that the above-mentioned questions have all been answered truthfully and accurately.
No relevant information has been deliberately withheld and I agree to provide documentation as reasonably required.
I agree to notify the company of any subsequent recovery or payment any to repay any payments made to me. I agree that all rights of subrogation and recovery are transferred to the company.

SIGNED _____ DATE _____

NB. Due to possible recovery of claims, we urgently request you not to make any arrangements or agreements with regard to any compensation with possible liable persons or their insurance company, without first consulting us.