Camps & Clinics Claim Form

Institution: UW- _____

Type of Camp/Clinic _____

The Injury Claim Form should be sent to the following:

Kelly Eisenbies
Arthur J. Gallagher Risk Management Services, Inc.
245 South Executive Drive – Suite 200
Brookfield, WI 53005
Phone: 617-769-6464
Email: Kelly_Eisenbies@ajg.com

ACCIDENT CLAIM

(To Be Completed By the Injured Person / Parent)

FULL NAME (INJURED PERSON)			**SOCIAL SECURITY NUMBER**
STREET ADDRESS			**TELEPHONE NUMBER (INCLUDE AREA CODE)**
CITY OR TOWN, STATE, ZIP			**DATE OF BIRTH**
PARENT'S NAME AND PHONE			**PARENT'S E-MAIL**
PRIMARY HEALTH INSURANCE COMPANY:			
POLICY HOLDER'S NAME Board of Regents of the University of Wisconsin System			**PHYSICIAN'S OR SURGEON'S NAME**
STREET ADDRESS 780 Regent Street, Suite 145			**PHYSICIAN'S STREET ADDRESS, CITY, STATE, ZIP**
CITY OR TOWN, STATE, ZIP Madison, WI 53715			**PHYSICIAN'S TELEPHONE NUMBER**
POLICY NUMBER BSRE897166-00			**IF HOSPITALIZED, NAME OF HOSPITAL**
WHEN WERE YOU INJURED?	**DATE**	**TIME** **AM/PM**	**HOSPITAL STREET ADDRESS, CITY, STATE, ZIP**
WHERE WERE YOU INJURED?			
TYPE OF INJURY (BODY PART)			**NAME OF EVENT / ACTIVITY**
DESCRIBE FULLY HOW ACCIDENT OCCURRED (Attach Separate Sheet if Necessary)			

AUTHORIZATION TO PAY BENEFITS TO PROVIDER

I authorize medical payments to physician or supplier describe on any attached statements enclosed.

Signature _____ Date _____

I hereby authorize any insurance company, hospital, physician, or other person who has attended or examined the claimant to disclose when requested to do so, all information with respect to any injury, policy coverage, medical history, consultation, prescriptions or treatment, and copies of all hospital or medical records. A photo static copy of this authorization shall be considered as effective and valid as the original.

Signature _____ Date_____

By entering your name above in Part II, you are signing this claim form electronically. You agree your electronic signature is the legal equivalent of your manual/handwritten signature on this claim form.

1. Please fully complete this form and submit to Kelly with Gallagher.
2. Moving forward, all corresponding itemized bills and EOBs should be sent to to A-G Administrators.

A-G Administrators, PO Box 21013, Eagan, MN 55121
Phone: (610) 933-0800 | Fax: (610) 935-2860 | Email: Claims@agadm.com