File # _____

SISC CLAIM FORM

☐ STUDENT ACCIDENT
☐ SUPPLEMENTAL COVERAGE

(Grades Preschool through 12)

Mail To: SISC Student Accident Claims, P.O. Box 1847,
Bakersfield, CA 93303-1847 - (661) 636-4710

TO BE COMPLETED BY SCHOOL OFFICIAL

Did the accident occur **during** (*Check Yes or No*)

A. Non-school related activity?	☐ Yes	☐ No
B. Supervised school activity?	☐ Yes	☐ No
C. Field trip activity?	☐ Yes	☐ No
D. Supervised off-campus activity?	☐ Yes	☐ No
E. Sponsored and supervised travel?	☐ Yes	☐ No
F. Supervised athletic practice/competition?	☐ Yes	☐ No

Sport_____

Name and Title of Supervising School Authority:

Name_____

Title _____

Signature_____

School District _____

School Name_____

STUDENT INFORMATION

STUDENT'S FULL NAME | MAILING ADDRESS | CITY | ZIP

DATE OF BIRTH | SOCIAL SECURITY # | GRADE | SEX ☐ M ☐ F | TELEPHONE

1. Give full description of injury. Tell when, where, and how it happened.

2. Give exact date and time when injury occurred. Date: _____ Time:_____ a.m. _____p.m.

3. When did you first consult a physician for this condition? Date: _____

TO BE COMPLETED BY PARENT
PARENT INFORMATION

SISC Accident Coverage is secondary to your private health insurance.

1. Father's Name_____ EMPLOYED: Yes_____ No_____

Father's Employer _____ Employer Telephone (_____) _____

Individual and/or
Group Insurance Company _____ Policy # _____

SOCIAL SECURITY # _____ Is child covered by this insurance? Yes_____ No_____

I authorize the release of any information necessary to process this claim.

Father's
Signature_____Date_____

I authorize payment of medical benefits to physician or supplier of service.

Father's
Signature_____Date_____

2. Mother's Name _____ EMPLOYED: Yes_____ No_____

Mother's Employer _____ Employer Telephone (_____) _____

Individual and/or
Group Insurance Company _____ Policy # _____

SOCIAL SECURITY # _____ Is child covered by this insurance? Yes_____ No_____

I authorize the release of any information necessary to process this claim.

Mother's
Signature_____Date_____

I authorize payment of medical benefits to physician or supplier of service.

Mother's
Signature_____Date_____

IMPORTANT - PARENT'S RESPONSIBILITY: All hospital and doctor bills must be itemized.
NOTICE TO PROVIDERS: A copy of this claim form needs to be attached to your bill.