NOTICE

WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subjected to civil fines and criminal penalties. California Residents: For your protection California law requires the following to appear on this form: "Any person knowingly present false or fraudulent claim for the payment of loss is guilty of a crime and may be subject to fines and confinement in state prison."

Part A – This PART MUST be completed, dated, and signed by an official or the Organization.

1. Name of Organization (Policyholder)

MIDLANDS TECHNICAL COLLEGE

2. Policy No.

3. Name of Organization or Team (if Different from Policyholder)

4. Address of Organization	(Street)	(City)	(State)	(Zip)
P. O. Box 2408		**Columbia**	**SC**	**29202**

5. Name of Injured Person (Insured)	(First)	(Middle)	(Last)

6. Date of Accident/Injury Mo Day Year	7. Injury Occurred: Practice Travel Game Other ________________________	8. Type of Sport or Activity:

9. Explain HOW the accident and injury occurred. NOTE: If your organization uses an Accident Report attach a copy of the Report.

10. Describe the nature of injury.

11. At the time of the accident, was the Person involved in an activity under the jurisdiction of the Organization (Policyholder)? Yes ☐ No ☐	12. Name of Supervisor of Activity	13. Was he/she a witness to the injury? Yes ☐ No ☐

14. Signature of Organization Official **X**________________________	15. Title of Official	16. Area Code/Telephone No. ( )	17. Date Signed

PART B – this PART MUST be completed, dated, and signed by the Injured Person – or if the Injured is under the age of 18 or otherwise dependent - by his/her Parent or Guardian.

PRINT HERE – NAME OF PERSON COMPLETING FORM

Check One: Injured Person ☐ Parent ☐ Guardian ☐

Give the following information about the injured Person:

1. Date of Birth Mo Day Year / /	2. Male ☐ Female ☐	3. Social Security No. or Student Visa No.	4. Area Code/Telephone No. ( )

5. Address (Street) (City) (State) (Zip)

6. Employer (Name) (Street) (City) (State) (Zip)

Area Code/Telephone No.
( )

7. Is the Injured Person covered under any other health and/or accident insurance plan? Yes ☐ No ☐
If YES, give the following information:

Name of other Insurance Company(s)	Address of Other Insurance Company(s)	Policy Number(s)	Name of Policyholder(s)

8. If the Injured Person is under 18 or otherwise dependent, give the following information:

Name of Father or Male Guardian

Social Security No.
/ /

Place of Employer

Area Code/Employer Phone No.
( )

Address of Employment

Name of Mother or Female Guardian

Social Security No.
/ /

Place of Employer

Area Code/Employer Phone No.
( )

Address of Employment

9. If the Insured Person is married, give the following information:

Name of Spouse

Social Security No.
/ /

Place of Employer

Area Code/Employer Phone No.
( )

Address of Employment

I hereby authorize any physical or medical practitioner, hospital, other organization, institution, or person that has any medical records or knowledge of me or my family as to diagnosis, treatment, and prognosis regarding any physical, mental, drug or alcohol condition of any and all such information to be given to the Society of Underwriters at Lloyds, London or its authorized Administrator or their legal representatives. Any information obtained will not be released by the Company except to persons or organizations performing business or legal services in connection with my application or claim.. A photocopy of this authorization shall be valid as the original and is valid for 24 months from the date shown below. I understand I or my authorized representative will receive a copy of this authorization upon request.

Chose One: ☐ Injured Person
☐ Parent
☐Guardian

X ________________________________ Signature (in writing) of Responsible Party

________________________ Print Name

______________ Date