Liberty Mutual Insurance
Claims Department
PO Box 704000
Salt Lake City, UT 84170-4000
P: (800) 921-2335
F: (800) 625-8095
TuitionInsuranceClaims@LibertyMutual.com

How to Complete and File Tuition Insurance Claims: Student

Please use this form to submit Tuition Insurance claims, following the instructions below. We will evaluate your claim based on the terms and conditions of your insurance coverage. Upon receipt of the completed forms a claims specialist will contact you to discuss the claim, answer any questions, and explain the next steps.

Please review your policy to see your specific benefits. If you have questions, call us toll-free at 1-800-921-2335 or send an email toTuitionInsuranceClaims@LibertyMutual.com.

1. Carefully read the applicable fraud warning notice on page 2.

2. Have the name insured sign the authorization on page 3.

- If you are an authorized representative, include a copy of the legal document(s) authorizing you to act on the patient's behalf.

3. Complete the School/University Withdrawal Information Release Part 1 or Part 2 (as applicable) on page 4.

- Forms will be considered non-valid if they are completed by anyone other than the Student (if at least 18 years of age at policy issuance), Parent, Guardian, or Authorized Personal Representative

4. Submit your completed form and required documentation by mail, email, or via fax

Mail:
Claims Department
PO Box 704000
Salt Lake City, UT 84170-4000

Email: TuitionInsuranceClaims@LibertyMutual.com

Fax: (800) 625-8095

A copy of this authorization will be considered as valid as the original.

The acceptance of a claim form by an insurance company is not an admission of coverage, nor does it recognize the validity of any claim.

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FRAUD WARNING NOTICE

For states not listed below: 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 is guilty of a crime and may be subject to fines and confinement in prison.

Arizona	For your protection, Arizona law requires the following statement to appear on this form: Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.
Arkansas, Louisiana Martland Texas	Any person who knowingly presents a false or fraudulent claim for payment of a loss or Benefit or (in ar, la or md) knowingly presents false information in an application for Insurance is guilty of a crime and may be subject to fines and confinement in prison.
California	For your protection, California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.
Colorado	It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, and denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.
Delaware Idaho Indiana	Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.
Florida	Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.
Kentucky	Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.
Minnesota	A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.
New Hampshire	Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in NH Rev. Stat. Ann. §638:20.
New Jersey	Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.
New Mexico	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 is guilty of a crime and may be subject to civil fines and criminal penalties.
New York	Any person who knowingly and with intent to defraud any insurance company or other p erson files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation.
Ohio	Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.
Oklahoma	WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.
Oregon	Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly or willfully presents false information in an application for insurance may be guilty of a crime, and may be subject to fines and confinement in prison.
Pennsylvania	Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.
Virginia Washington Other States	It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines or a denial of insurance benefits.

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Authorization for the release of information, including protected health information

I hereby authorize the use or disclosure of information about me as described below:

1. **Person(s) or group(s) of persons authorized to use or disclose the information:**
   Any physicians, medical practitioners, hospitals, clinics, HMOs, long-term care facilities, medical or medically-related facilities, pharmacies, insurance companies, financial/educational institutions, current or former employer, governmental agency, the Medical Information Bureau, and any insurance support organizations.
2. **Person(s) or group(s) of persons authorized to collect or otherwise receive the information:**
   The particular Company in the Liberty Mutual Group of companies to which I am submitting a claim and its authorized representatives, agents and/or employees and other organizations providing claims management services.
3. **Description of the information that may be used or disclosed:**
   This Authorization specifically includes the release of all information related to:
   - ✓ My physical and mental health that is the basis of my insurance claim, including, but not limited to, those containing diagnosis, treatments, prognosis, prescription drug information, alcohol or drug abuse or information regarding communicable or infectious conditions, including HIV/AIDS.
   - ✓ My student status at my college, my school expenses, and any other information held by the school relevant to my insurance claim.
4. **The information will be used or disclosed only for the following purpose(s):**
   For purposes of investigating, evaluating and processing my claim, and/or for insurance-related functions.

Statements of understanding & acknowledgment:

- ✓ I understand that information used or disclosed pursuant to this authorization could be subject to redisclosure as necessary by the recipient and if so, may not be subject to federal or state law protecting its confidentiality.
- ✓ I understand that I may revoke this authorization in writing at any time by sending a written revocation to the Company in the Liberty Mutual Group of companies to which I have submitted a claim, except to the extent that action has been taken in reliance on this authorization, or to the extent that other law provides the Company with the right to contest a claim. I also understand that the revocation of this authorization will not affect uses and disclosures of my health information for purposes of treatment, payment and health care operations.
- ✓ I understand that authorizing the disclosure of my health information is voluntary and the provision of health care services to me is not conditioned on whether I sign this authorization. If I choose not to sign this authorization, payments of benefits may be denied or delayed.
- ✓ This authorization shall remain in force for 24 months from the date of signature, except to the extent applicable state law imposes or allows a different duration. The information obtained under this authorization will be retained in accordance with the Company's standard retention policy and applicable law.

Printed name of student/authorized representative:	Date
Signature of student/authorized representative:	Date
If applicable, describe relationship to Student:	
Student's date of birth:	

A copy of this authorization will be considered as valid as the original.

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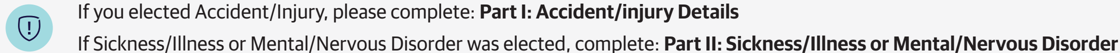
SCHOOL / UNIVERSITY WITHDRAWAL INFORMATION RELEASE: NAME INSURED
Must be completed by Student, Parent, Guardian, or other Authorized Representative

Reason for Withdrawal: *(Check one)* ☐ Accident / Injury ☐ Sickness/Illness ☐ Mental/Nervous Disorder


If you elected Accident/Injury, please complete: **Part I: Accident/injury Details**
If Sickness/Illness or Mental/Nervous Disorder was elected, complete: **Part II: Sickness/Illness or Mental/Nervous Disorder**

PART I: ACCIDENT/INJURY DETAILS

Date of accident:	Time of accident: ☐ a.m. ☐ p.m.
Location of accident:	
Describe in detail the events leading up to the accident and how the accident happened: *(If the accident involved a motor vehicle, please submit a copy of the police report.)*	
Is any other insurance involved? *(If Yes, please provide policy details):* ☐ Yes ☐ No	
Was the patient hospitalized for this injury? ☐ Yes ☐ No	Hospital name:
Physician Name and Address:	Admission date:
	Discharge date:

PART II: SICKNESS/ILLNESS OR MENTAL/NERVOUS DISORDER

Describe your illness::	
When did symptoms first appear?	
Have you ever had the same or similar condition? ☐ Yes ☐ No	When?
Were you hospitalized for this illness? ☐ Yes ☐ No	Hospital Name:
Physician Name and Address:	Admission date:
	Discharge date:

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Student Name: *(Last, First, Middle Initial):*	**Student ID:**
Phone Number:	**Email:**

Please see page 2 of this form for important fraud information regarding your claim.

The above statements are true to the best of my knowledge and belief, and I have read the applicable fraud warning notice on page 2 of this form.

I HEREBY AUTHORIZE the School / University to release information requested below and other such information which is necessary to verify withdrawal from the School / University to Liberty Mutual Insurance for use in documentation of claim related to Comprehensive Tuition & Fees Refund Insurance Coverage in effect at this time.

For residents of New York:
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation.

Name of Student/Authorized Representative *(Print)*	**Date**
Signature of Student/Authorized Representative	**Description (Title) of Authorized Representative:**

AUTHORIZATION FOR LIBERTY MUTUAL TO RELEASE HEALTH INFORMATION TO YOUR SCHOOL

Upon a request from my school, I authorize Liberty Mutual to disclose medical information submitted for my claim seeking tuition reimbursement (which may include information with respect to any physical or mental condition and/or treatment of me, including information about HIV/AIDS, communicable diseases, alcohol and substance abuse, and mental health), for the purpose of evaluating my claim for tuition reimbursement. This authorization is separate and unrelated to my authorization for release of information to Liberty Mutual Insurance Company for investigating, evaluating, and processing my claim.

Name of Student/Authorized Representative *(Print)*	**Date**
Signature of Student/Authorized Representative	**Description (Title) of Authorized Representative:**

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