



WESTERN  
ILLINOIS  
UNIVERSITY

## Western Illinois University Student Claim Form

If you need assistance completing this form, please contact the Student Insurance Office.  
Please return completed form to

Student Health Insurance Staff  
1 University Circle  
Lower Level / Beu Health Center  
Macomb, IL 61455  
PH: (309) 298-1882  
Fax: (309) 298-2363  
TT: (309) 298-1856 (For the Hearing Impaired)

1. Name of Student \_\_\_\_\_ Student ID # \_\_\_\_\_  
Address \_\_\_\_\_
2. When did symptoms first appear or accident happen? \_\_\_\_\_
3. What is the date of the medical emergency? \_\_\_\_\_
4. What is the injury or sickness? \_\_\_\_\_
5. If this is for an injury, describe how and where accident occurred. Give complete details: \_\_\_\_\_
6. Did injury occur while working? \_\_\_\_\_
7. If injured during practice or play of sports, what type of sport was involved? (Check one.)  
 Intramural  Interscholastic  Other \_\_\_\_\_
8. Name and Address of Doctor Seen for This Claim \_\_\_\_\_
9. Do you have other insurance besides WIU Student Insurance that would cover these bills?  
 Yes  No

**CLAIMS MUST BE SUBMITTED WITHIN 12 MONTHS FROM THE DATE OF SERVICE  
TO BE CONSIDERED UNDER THIS PLAN.**

Upon presentation of the original or photocopy of this signed authorization, I authorize any medical professional, hospital, clinic, or other medical or medically related facility, government agency, or other person or firm to provide information, including copies of records, concerning advice, care, or treatment provided to me and/or my dependents, including, without limitation, information related to mental illness or use of drugs or alcohol, to Western Illinois University Student Insurance representatives or CTI Administration representatives involved in evaluating, determining, or administering claims for insurance benefits for me and/or my dependents. I understand that I or any authorized representative will receive a copy of this authorization upon request.

This authorization is valid from the date signed through the term of coverage of the policy or during the period to process the claims.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**IMPORTANT: PLEASE ATTACH ALL ITEMIZED BILLS.**  
[www.student.services.wiu.edu/beu/insurance/index.asp](http://www.student.services.wiu.edu/beu/insurance/index.asp)