AUTO | HOME | LIFE

Liberty Mutual Insurance

Claims Department
PO Box 66400
London, KY 40741
(800) 921-2335
(800) 625-8095 Fax
TuitionInsuranceClaims@LibertyMutual.com

How to Complete and File Tuition Insurance Claims: Name Insured

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 to TuitionInsuranceClaims@LibertyMutual.com.

1. Carefully read the applicable fraud warning notice on pages 2-3.
2. Have the name insured sign the authorization on page 4.
   - 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 pages 5-6
   - 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
P.O. Box 66400
London, KY 40741

Email: TuitionInsuranceClaims@LibertyMutual.com
Fax: (800) 625-8095

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.

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

Liberty Mutual Insurance

Tuition Insurance Claims Department
PO Box 66400
London, KY 40741
(800) 921-2335
(800) 625-8095 Fax
TuitionInsuranceClaims@LibertyMutual.com

IMPORTANT NOTICE

To Arizona Claimant
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.

TO CLAIMANTS IN ARKANSAS, LOUISIANA, MARYLAND AND 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.

To California Claimants
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.

To Colorado Claimants
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, 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.

To Claimants in Delaware, Idaho and 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.

To Florida Claimants
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 of the third degree.

To Kentucky Claimants
Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

To Minnesota Claimants
A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

To New Hampshire Claimants
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 RSA 638:20.

To New Jersey Claimants

Liberty Mutual Insurance

Tuition Insurance Claims Department
PO Box 66400
London, KY 40741
(800) 921-2335
(800) 625-8095 Fax
TuitionInsuranceClaims@LibertyMutual.com

Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

TO NEW MEXICO CLAIMANTS
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.

To New York Claimants
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 five thousand dollars and the stated value of the claim for each such violation.

To Ohio Claimants
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.

To Oklahoma Claimants
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.

To Oregon Claimants
Any person who knowingly and with the intent to defraud any insurer provides false or misleading information concerning any fact material to a risk to be insured or to a claim for loss or benefits may be guilty of a crime.

To Pennsylvania Claimants
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.

To Claimants in Virginia, Washington and any State not listed above

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.

AUTO | HOME | LIFE

Liberty Mutual Insurance

Tuition Insurance Claims Department
PO Box 66400
London, KY 40741
(800) 921-2335
(800) 625-8095 Fax
TuitionInsuranceClaims@LibertyMutual.com

AUTHORIZATION FOR THE RELEASE OF INFORMATION INCLUDING PROTECTED HEALTH INFORMATION

I HEREBY AUTHORIZE THE USE OR DISCLOSURE OF INFORMATION ABOUT ME AS DESCRIBED BELOW:

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.

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.

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

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, insurance coverage or claim payments 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. I understand that I may request a copy of this authorization.

Name of Individual/Authorized Representative (Print)	
Name of Individual/Authorized Representative (Signature)	
Describe Relationship to Student	
Date of Birth (Student):	Date:

Liberty Mutual INSURANCE
AUTO | HOME | LIFE

Liberty Mutual Insurance
Tuition Insurance Claims Department
PO Box 66400
London, KY 40741
(800) 921-2335
(800) 625-8095 Fax
TuitionInsuranceClaims@LibertyMutual.com

SCHOOL / UNIVERSITY WITHDRAWAL INFORMATION RELEASE: NAME INSURED

To be completed by Student, Parent, Guardian, or other Personal Representative

1. Reason for Withdrawal: (Check one)

Accident / Injury	Sickness/Illness		Mental/Nervous Disorder
☐	☐		☐

- **Before moving on:** If you elected Accident/Injury, please complete- **Loss Details Part 1**: Accident/injury Details
- If Sickness/Illness or Mental/Nervous Disorder was elected, complete- **Loss Details Part 2**: Sickness/Illness or Mental/Nervous Disorder

Loss Details Part 1: Accident/injury Details:

Date of accident:	**Time of accident:**	☐ a.m. ☐ p.m.
Location of accident:		
Please 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? ☐ Yes ☐ No	**If Yes, please provide policy details**	
Was the patient hospitalized for this injury? ☐ Yes ☐ No	**Hospital name:**	
Physician Name:	**Physician Address:**	
Admission date:	**Discharge date:**	

Loss Details Part 2: Sickness/Illness or Mental/Nervous Disorder

Please describe your illness:		
When did symptoms first appear?		
Have you ever had the same or similar condition? ☐ Yes ☐ No	**If yes, when?**	
Were you hospitalized for this illness? ☐ Yes ☐ No	**Hospital name:**	
Physician Name:	**Physician Address:**	
Admission date:	**Discharge date:**	

Liberty Mutual Insurance

Tuition Insurance Claims Department
PO Box 66400
London, KY 40741
(800) 921-2335
(800) 625-8095 Fax
TuitionInsuranceClaims@LibertyMutual.com

Name of Insured Student:		**Student ID:**
Name of Tuition Payer:		

Please see pages 2-3 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 pages 2 and 3 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 Claimant/Personal Representative (Print)	
Name of Claimant/Personal Representative (Signature)	
Description (Title) of Personal Representative	
Date	

Please see pages 2-3 of this form for important fraud information regarding your claim.

AUTO | HOME | LIFE

Liberty Mutual Insurance

Tuition Insurance Claims Department
PO Box 66400
London, KY 40741
(800) 921-2335
(800) 625-8095 Fax
TuitionInsuranceClaims@LibertyMutual.com

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 Claimant/Personal Representative (Print)	
Name of Claimant/Personal Representative (Signature)	
Description (Title) of Personal Representative	
Date	