# SISC Tackle Football Claim Form

- Tackle Football Accident
- Supplemental Coverage

**Mail To:** SISC Tackle Football, P.O. Box 1847,
Bakersfield, CA 93303-1847 - (661) 636-4710

## TO BE COMPLETED BY SCHOOL OFFICIAL

<table>
<thead>
<tr>
<th>Did the accident occur (Check Yes or No)</th>
<th>Name and Title of Supervising School Authority:</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. During school sponsored</td>
<td>Name</td>
</tr>
<tr>
<td>tackle football practice?</td>
<td>Title</td>
</tr>
<tr>
<td>B. During school sponsored</td>
<td>Signature</td>
</tr>
<tr>
<td>tackle football competition?</td>
<td>School District</td>
</tr>
<tr>
<td>C. During school sponsored and</td>
<td>School Name</td>
</tr>
<tr>
<td>supervised tackle football transportation?</td>
<td></td>
</tr>
</tbody>
</table>

## STUDENT INFORMATION

<table>
<thead>
<tr>
<th>STUDENT'S FULL NAME</th>
<th>MAILING ADDRESS</th>
<th>CITY</th>
<th>ZIP</th>
</tr>
</thead>
<tbody>
<tr>
<td>DATE OF BIRTH</td>
<td>GRADE</td>
<td>SEX</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>M</td>
<td>F</td>
</tr>
<tr>
<td></td>
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</tr>
</tbody>
</table>

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:** Injuries MUST be treated by a properly authorized Physician or Dentist. All hospital and doctor bills must be itemized.