

**IMPORTANT INFORMATION ABOUT FILING
YOUR CLAIM FOR TUITION REFUND**

1. PART 1 must be completed by the School Office.
2. PART 2 must be completed by Parent or Legal Guardian of the withdrawing student.
3. PART 3 must be completed if the withdrawal is due to job loss or job transfer.
4. PART 4 must be completed by the attending physician, if the withdrawal is due to medical necessity.

**MAIL YOUR COMPLETED CLAIM FORM
AND ATTACHMENTS TO:**



**Markel Insurance Company
P. O. Box 3870
Glen Allen, VA 23058**

TUITION REFUND CLAIM FORM

School: _____ Policy #: _____

PART 1: School Information (To be completed by School Office)

The above named student has withdrawn from our institution for the following reason:

Medical Disability Job Transfer Voluntary - describe reason: _____
 Mental/Nervous Disorder Academic Death of the Student
 Involuntary Job Loss Disciplinary Governmental Shutdown - Describe _____

Date of First Day of Current School Year: _____ Date of Last Day of Current School Year: _____
M/D/Y M/D/Y

Actual Calendar Days in School Year: _____

Date Student Enrolled: _____ Date of Student Withdrawal: _____
M/D/Y M/D/Y

Student's Grade: _____ Student's Reported Covered Fees: _____ Day Student Boarding Student

Has student completed the academic requirements for the current school year, or graduated early? Yes No

We hereby certify that the above information is correct and complete to the best of our knowledge.

Name and Title of School Official: (please print): _____

Signature of School Official: _____ Date: _____

Phone Number: () _____

PART 2: Student and Tuition Payer Information

Student Name: _____ Male Female

Tuition Payer Name: _____ Home Tel: () _____

Home Address: _____ Work Tel: () _____
Street

Spouse's Name: _____ Home Tel: () _____
City State Zip

Home Address: _____
Street

City State Zip



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PART 3: Employer Information (*Complete only if withdrawal is due to job loss or job transfer*)

Name of Employer: _____

Employer Address: _____

Employer Telephone: () _____ Applicable To: Tuition Payer Spouse

Tuition Payer Social Security Number: _____ Spouse Social Security Number: _____

AUTHORIZATION TO RELEASE INFORMATION: I authorize any medical provider, medical care facility, insurer, government-sponsored health plan, school, college, university, or employer having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me or my minor children and any other non-medical information of me or my minor children to give Markel Insurance Company or its legal representative, any and all such information. I understand the information obtained by use of the Authorization will be used by Markel Insurance Company to determine eligibility for insurance, and eligibility for benefits under any existing policy. A copy of this authorization (one of which will be given to me by the Company upon my request) will be valid as this one. I certify that the above information given by me in support of this claim is true and correct.

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.

Signature of Tuition Payer: _____ Date: _____
(Student Signature, if of legal age)



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PART 4: Attending Physician Statement (To be completed by Physician)

Patient's Name _____ Date of Birth _____

1. Condition causing disability is due to the following: <input type="checkbox"/> Accident <input type="checkbox"/> Sickness <input type="checkbox"/> Mental/Nervous Disorder
2. Give date symptoms first appeared, or the date accident occurred. _____ Month/Day/Year
3. Give date the patient <u>first</u> consulted you for this condition. _____ Month/Day/Year
4. Give date the patient <u>last</u> consulted you for this condition. _____ Month/Day/Year
5. Is patient still under your care for this conditions? <input type="checkbox"/> Yes <input type="checkbox"/> No
6. Has patient ever had the same or similar condition? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, state when and describe.
7. Did the condition result from the use of drugs or other narcotics not prescribed by a physician? <input type="checkbox"/> Yes <input type="checkbox"/> No
8. Describe any other disease or infirmity affecting present condition.
9. List dates of all treatment received by patient.
10. Is the patient, or has the patient ever been, hospitalized for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, give dates of confinement in hospital. Provide name and address of hospital in which confinement occurred. NAME OF HOSPITAL _____ HOSPITAL ADDRESS _____ Confined from _____ through _____
11. Have you referred patient to another physician? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, give name and address of physician:
12. Have you recommended this student withdraw from classes? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, give date you anticipate patient will be able to resume classes:
13. Describe reasons for recommending withdrawal from classes.
14. Has the patient attended classes at any school, or become employed since the date of withdrawal? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, give date activity began.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize Markel Insurance Company to inspect or secure copies of case history records, laboratory reports, diagnoses, prognoses, and any other data covering this or other confinements and disabilities.

PHYSICIAN NAME (please print): _____ DATE: _____

PHYSICIAN SIGNATURE: _____ DATE: _____

PHYSICIAN ADDRESS: _____

PHONE: () _____



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EMPLOYER CERTIFICATION FORM

Employee Name: _____

Social Security Number: _____

PART A: Complete if employee is no longer employed with your company

Give employee start date: _____ Give date unemployment began: _____

Give reason for unemployment: _____

Please indicate if unemployment was: Voluntary Involuntary

PART B: Complete if employee was transferred to another geographic location with your company

Give date of transfer: _____

How many miles is the new geographic locale from the employee's current job location? _____

We hereby certify that the above information is true and correct.

Name and Title of Company Official: _____
Name Title

Signature of Company Official: _____ Date: _____

Telephone Number of Company Official: () _____ Ext: _____

PLEASE RETURN COMPLETED FORM TO:



**Markel Insurance Company
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