



# Tuition Refund Claim Form

**Return Completed Form To:**

Claims Department  
241 A Street, Suite 400  
Boston, MA 02210  
F: 617-410-9042  
E: [claims@gradguard.com](mailto:claims@gradguard.com)

**Instructions for Filing a Claim**

1. Part 1 must be completed by the student or tuition payer.
2. Part 2 must be completed by School Office.
3. Part 3 must be completed by the attending physician, if the withdrawal is due to medical necessity

Student Name (Last, First, MI)

Policy #: 4702AH331289

**PART 1: STUDENT & TUITION PAYER INFORMATION****To be completed by student or tuition payer**

Student Name (Last, First, MI)		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	
Tuition Payer Name		Phone Number	
Tuition Payer's Home Address		City	State Zip
Spouse's Name		Phone Number	
Spouse's Home Address		City	State Zip

**AUTHORIZATION FOR RELEASE OF INFORMATION**

I AUTHORIZE any physician, medical care provider, hospital, clinic, medical care facility, insurance company, government-sponsored health plan, or employer having information available as to diagnosis, treatment and prognosis with respect to any illness, injury, physical or mental condition, and/or treatment for me or my minor children now or in the past, to give to Markel Insurance Company (MIC) or its legal representative, any and all such information.

I UNDERSTAND the information obtained by use of the Authorization will be used by MIC to determine eligibility for insurance and eligibility for benefits under any existing policy. Any information obtained will not be released by MIC to any person or organization EXCEPT as necessary in connection with the processing of this application, claim, or as may be otherwise lawfully required or as I may further authorize.

I KNOW that I may request a copy of this Authorization.

I AGREE that a photographic copy of this Authorization shall be valid as the original. I also AGREE this Authorization shall be valid for a period of two years from the date shown below. I may revoke this authorization at any time by written request to MIC.

Tuition Payer Signature: \_\_\_\_\_

(Student Signature, if of legal age)

Date: \_\_\_\_\_

MM/DD/YYYY

**Please Note**

In furnishing this or other claim forms for the convenience of the claimant, the MARKEL INSURANCE COMPANY does not admit any liability or waive any rights. MARKEL INSURANCE COMPANY reserves the right to ask for other information if it is deemed necessary. All expenses incurred in connection with furnishing the necessary proof of loss are the responsibility of the covered person.



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**PART 2: SCHOOL INFORMATION**  
**To be completed by School Office**

**Instructions for school:** Please complete this form and return to the student or tuition payer, along with a letter from the school acknowledging the reason for the students withdrawal from your institution.

Name: \_\_\_\_\_

School: \_\_\_\_\_

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

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Medical Disability      | <input type="checkbox"/> Medical Illness | <input type="checkbox"/> Voluntary - describe: _____ |
| <input type="checkbox"/> Mental/Nervous Disorder | <input type="checkbox"/> Academic        | <input type="checkbox"/> Death of Student            |
| <input type="checkbox"/> Medical Injury          | <input type="checkbox"/> Disciplinary    | <input type="checkbox"/> Death of Tuition Payer      |

Date of First Day of Current School Year: \_\_\_\_\_

Date of Last Day of Current School Year: \_\_\_\_\_

Actual Calendar Days in School Year: \_\_\_\_\_

Date Student Enrolled: \_\_\_\_\_

Date of Student Withdrawal: \_\_\_\_\_

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: \_\_\_\_\_

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## **PART 3: ATTENDING PHYSICIAN STATEMENT**

### **To be completed by School Office**

**Instructions for Physician:** Please complete this form and return to the student or tuition payer, along with a letter outlining the recommendation for medical withdrawal to protect the students wellbeing.

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

1. Condition causing disability is due to the following: ☐ Accident/Injury ☐ Sickness ☐ Mental/Nervous Disorder

2. Give date symptoms first appeared, or the date accident occurred: \_\_\_\_\_

3. Give date the patient first consulted you for this condition: \_\_\_\_\_

4. Give date the patient last consulted you for this condition: \_\_\_\_\_

5. Is patient still under your care for these conditions? ☐ Yes ☐ No

6. Has patient ever had the same or similar condition? ☐ Yes ☐ No

If yes, state when and describe: \_\_\_\_\_

7. Did the condition result from the use of drugs ☐ Yes ☐ No

8. Describe any other disease or infirmity affecting present condition: \_\_\_\_\_

9. List dates of all treatment received by patient: \_\_\_\_\_

10. Has the patient ever been hospitalized for this condition? ☐ Yes ☐ No

If Yes, give the dates of confinement in hospital. Provide name and address of hospital in which confinement occurred:

Name of Hospital: \_\_\_\_\_ Confined from \_\_\_\_\_ to \_\_\_\_\_

Hospital Address: \_\_\_\_\_

11. Have you referred the patient to another physician? ☐ Yes ☐ No

If Yes, give name and address of physician: \_\_\_\_\_

12. Have you recommended this student withdraw from classes? ☐ Yes ☐ No

If Yes, give the date you anticipate patient will be able to resume class: \_\_\_\_\_

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? ☐ Yes ☐ 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, diagnose, prognoses, and any other data covering this or other confinements and disabilities.

Physician Name (please print): \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician Address: \_\_\_\_\_ Date: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

## FRAUD STATEMENTS

**GENERAL:** 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.

**ALASKA:** Any person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

**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:** 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.

**CALIFORNIA:** For your protection, California law requires the following to appear on this form: Any person who knowingly presents a 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, 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:** 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.

**DISTRICT OF COLUMBIA RESIDENTS: WARNING:** It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

**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.

**IDAHO:** Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

**INDIANA:** A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

**KENTUCKY:** 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.

**LOUISIANA:** 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.

**MAINE:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

**MARYLAND:** Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**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 RSA 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 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.

**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 with intent to defraud or solicit another to defraud an insurer: (1) by submitting an application, or (2) by filing a claim containing a false statement as to any material fact, may be violating state law.

**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 act, which is a crime and subjects such person to criminal and civil penalties.

**TENNESSEE:** 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 and denial of insurance benefits.

**TEXAS:** Any person who knowingly presents a 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.

**VIRGINIA:** 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 and denial of insurance benefits.

**WEST VIRGINIA:** 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.