

Please sign & forward to the TASO office (email to astager@taso.org or fax 512-345-9947

PART B – This PART MUST be completed, dated and signed by the Injured Person – or if the Injured Person is under age 18 or otherwise dependent – by his/her Parent or Guardian.

PRINT HERE – NAME OF PERSON COMPLETING FORM

Check one: Injured Person Parent Guardian

Give the following information about the Injured Person:

1. Date of Birth Mo Day Year / /	2. Male <input type="checkbox"/> Female <input type="checkbox"/>	3. Social Security No. or Student Visa No. / /	4. Area Code/Telephone No. ()
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5. Address (Street) (City) (State) (Zip)

6. Employer (Name) (Street) (City) (State) (Zip)

Area Code/Employer Telephone No.

()

7. Is the Injured Person covered under any other health and/or accident insurance plans? Yes No
If YES, give the following information:

Name of Other Insurance Company(s)	Address of Other Insurance Company(s)	Policy Number(s)	Name of Policyholder(s)
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8. If the Injured Person is under 18 or otherwise dependent, give the following information:

Name of Father or Male Guardian	Social Security No. / /
Place of Employment	
Address of Employer	Area Code/Employer Phone No. ()

Name of Mother or Female Guardian	Social Security No. / /
Place of Employment	
Address of Employer	Area Code/Employer Phone No. ()

9. If the Injured Person is married, give the following information:

Name of Father or Male Guardian	Social Security No. / /
Place of Employment	
Address of Employer	Area Code/Employer Phone No. ()

I hereby authorize any physician or medical practitioner, hospital, other organization, institution, or person that has any medical records or knowledge of me or my family as diagnosis, treatment, and prognosis regarding any physical, mental, drug or alcohol condition of any and all such information to be given to Berkley Group Companies: StarNet Insurance Company, Acadia Insurance Company, Great Divide Insurance Company or its authorized Administrator or their legal representatives. Any information obtained will not be released by the Company except to persons or organizations performing business or legal services in connection with my application or claim. A photocopy of this authorization shall be valid as the original and is valid for 24 months from the date shown below. I understand that my authorized representative or I will receive a copy of this authorization upon request.

X _____
Signature (in writing) of Responsible Party

Print Name

Check one: Injured Person
 Parent
 Guardian

Date: _____