

COLLEGE MEDICAL WITHDRAWAL CERTIFICATE

STEP I

STUDENT MEDICAL AUTHORIZATION

To be completed by Student, Parent or Guardian

Name of Insured Student _____ Social Security # _____

I HEREBY AUTHORIZE the physician to complete the Attending Physician’s Statement and to release this and other information to A.W.G. Dewar, Inc. for their use in documentation of claim for recovery of college fees from the insurance contract in effect at this time. I authorize the College/University to release the information requested below to A.W.G. Dewar, Inc. for the same purpose.

Date _____ Signature _____
(student if legal age, or parent or legal guardian)

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO FRAUD 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.

STEPS I and II should be completed and mailed to A.W.G. Dewar, Inc., 4 Batterymarch Park, Quincy, MA 02169-7468 as soon as possible; in any event, not later than 30 days after date of withdrawal.

STEP II

ATTENDING PHYSICIAN’S STATEMENT

This part to be completed by physician.

I HEREBY CERTIFY that _____, a student at _____, has been continuously under my care for _____

(diagnosis)
ICD CODE # _____ or DSM Code # _____

Continuing treatment from _____ through _____
(date) (date)

First consulted _____ Last consulted _____
(date) (date)

Number of professional visits for this disability: Home _____ Office _____ Hospital _____

Your answers to the questions below should clearly establish the medical necessity for separation from College.

1. Is student still under your care for the above disability? _____ (Yes/No)

2. If referred to another physician, please give the name and address: _____

If student referred to you by another physician, please give the name and address: _____

3. Has this student been withdrawn on your recommendation from classes for the rest of the current semester? _____ (Yes/No)

academic year? _____ (Yes/No). Please give reason for recommending or not recommending withdrawal: _____

4. When do you anticipate student will be able to resume classes at the above-mentioned College? _____

5. Has the withdrawal of this student resulted from the use of drugs or narcotics not authorized by a physician? _____ (Yes/No)

6. If disability was due to a psychological illness, was student confined to a hospital? _____ (Yes/No)

If **Yes** give dates of confinement and name and address of hospital. Confined from _____ through _____
(date) (date)

Hospital Name _____ Address _____

Signature of Physician _____, M.D. Date _____

Please print name _____ Physician License # _____

Please print address _____

College Medical Withdrawal Certificate

STEP I

To be completed by Student, Parent or Guardian

Name of Insured Student _____ Social Security # _____
Name of Tuition Payer _____ Social Security # _____

I HEREBY AUTHORIZE the College/University to release the information requested below and other such information which is necessary to verify my withdrawal from the College/University to A.W.G. Dewar, Inc. for their use in documentation of claim for recovery of college fees from the insurance contract in effect at this time. In the event there is an unpaid balance on my account at the time of withdrawal, I authorize A.W.G. Dewar, Inc. to pay the proceeds of the claim to the College/University for credit to my account. Benefits not required to settle my account will be refunded to me.

Date _____ Signature _____
(student if legal age, or parent or legal guardian)

Parent's / Student's Permanent Address _____
(please print)

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.

STEPS II (A) and (B) should be completed by the College/University and mailed to A.W.G. Dewar, Inc., 4 Batterymarch Park, Quincy, MA 02169-7468 as soon as possible; in any event, not later than 30 days after date of withdrawal.

STEP II (A)

To be completed by Dean of Students / Registrar

I HEREBY CERTIFY that _____ has completely withdrawn from classes due to medical reasons for the _____ semester or term as of _____ and will not receive **any** academic credit for this semester or term. I also certify that this student will not obtain an incomplete or take make-up examinations resulting in credit for these classes.

Signed: _____, Dean of Students / Registrar

STEP II (B)

To be completed by Business Office

I HEREBY CERTIFY that _____, a regularly enrolled student at _____ College/University, has withdrawn for medical reasons, as of _____.

Please complete the following area based **only** upon the contracted fees that are **insured** for the withdrawn semester.

	Insured Semester Costs	College will refund/credit under <u>its own refund schedule</u>
Tuition:	\$ _____	\$ _____
Room, Board and Fees:	\$ _____	\$ _____
Total Tuition, Room, Board and Fees:	\$ _____	\$ _____

Current outstanding balance (if any) on the student's account \$ _____

Signed _____ Title _____

FOR OFFICE USE ONLY

Policy # _____

INCLUSION DATE	CLAIM NO.	AMOUNT	CODE	APR.