COLLEGE MEDICAL WITHDRAWAL CERTIFICATE

STEP I — STUDENT INFORMATION RELEASE

To be completed by Student, Parent or Guardian

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

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. I authorize A.W.G. Dewar, Inc. to make settlement payable to the College/University for credit to my account, with any excess to be remitted to me through the College/University.

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

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

_____

PLEASE SEE THE REVERSE SIDE OF THIS FORM FOR IMPORTANT FRAUD INFORMATION REGARDING YOUR CLAIM.

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I HEREBY CERTIFY that _____ has completely withdrawn from classes for
(student name)
the _____ semester or term as of _____ and will not receive **any** academic credit for this semester or term.
(fall/winter/spring) (withdrawal date)
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
(student name)
at _____ College/University, has withdrawn as of _____.
(withdrawal date)

Please complete the following area based **only** upon the contracted fees that are **insured** for the withdrawn semester.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 its own refund schedule**
Tuition:	$ _____	$ _____
Fees:	$ _____	$ _____
Room:	$ _____	$ _____
Board (Meals):	$ _____	$ _____
Total of above:	$ _____	$ _____

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

Signed _____ Title _____

FOR OFFICE USE ONLY

Policy #

INCLUSION DATE	CLAIM NO.	AMOUNT	CODE	APR.

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. I understand that all claim payments are made to the College/University for credit to the student's account.

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

PLEASE SEE THE REVERSE SIDE OF THIS FORM FOR IMPORTANT FRAUD INFORMATION REGARDING YOUR CLAIM.

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 (Ph.D. and LCSW are permissible).

I HEREBY CERTIFY that _____, a student at _____,
(Student's Name) (College Name)
has been a patient under my care and withdrawn from college due to the following medical condition(s): _____

_____
(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: # of Home visits: _____ # of Office visits: _____ # of Hospital visits: _____

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

   _____

3. Do you medically certify that the sickness or injury diagnosed prevents the student from completing the rest of the current semester? ☐ YES ☐ NO academic year? ☐ YES ☐ NO Please give reason for your answer: _____

   _____

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. Was the student confined to a hospital for this sickness or injury? ☐ YES ☐ NO If **Yes,** provide dates of confinement and name and address of hospital. Confined from _____ through _____
   (date) (date)

   Hospital Name & Address _____

Licensed Provider Signature _____ Date _____

Please print name _____ License # _____

Please print address _____ Telephone# _____

IMPORTANT NOTICE

To Arizona Claimants

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.

TO CLAIMANTS IN ARKANSAS, LOUISIANA, MARYLAND AND TEXAS,

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR (in AR, LA or MD) KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

To California Claimants

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

To Colorado Claimants

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.

To Claimants in Delaware, Idaho and Indiana

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.

To Florida Claimants

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 of the third degree.

To Kentucky Claimants

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.

To Minnesota Claimants

A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

To New Hampshire Claimants

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.

To New Jersey Claimants

Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

TO NEW MEXICO CLAIMANTS

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.

To New York Claimants

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.

To Ohio Claimants

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.

To Oklahoma Claimants

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.

To Oregon Claimants

Any person who knowingly and with the intent to defraud any insurer provides false or misleading information concerning any fact material to a risk to be insured or to a claim for loss or benefits may be guilty of a crime.

To Pennsylvania Claimants

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 subjects such person to criminal and civil penalties.

To Claimants in Virginia, Washington and any State not listed above

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 or a denial of insurance benefits.