Please sign & forward to the TASO office: email Mona Schultz at mschultz@taso.org or fax to (214) 390-5353

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 which 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 ☐☐ Female ☐ ☐	3. Social Security No. or Student Visa No. / /	4. Area Code/Telephone No. ( )

Please note the Injured Person's Social Security Number MUST be provided as required by the Center for Medicare Services.

5. Address (Street) (City) (State) (Zip)

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

Area Code/ Employer Telephone No.
( )

7. Is the Injured Person covered under any other health and/or accident 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)

8. If the Injured Person is under 18 or otherwise dependent, give the following information:

Name of Father or Male Guardian

Place of Employment

Address of Employer Area Code/Telephone No.
( )

Name of Father or Female Guardian

Place of Employment

Address of Employer Area Code/Telephone No.
( )

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

Name of Wife or Husband

Place of Employment

Address of Employer Area Code/Telephone 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 Starr Indemnity and Liability 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 _____ _____ ☐ Injured Person ☐ Parent ☐ Guardian Date:_____
Signature (in writing) of Responsible Party Print Name