



# NOTIFICATION OF INJURY

This Notification of Injury Form is to be used for accident medical claims.

## **Policies With Excess Coverage**

Eligible covered expenses will be paid only if they are in excess of other valid and collectible insurance or medical payment plan. If the claimant is covered by any other insurance or medical payment plan they must first submit claim to the primary insurance first. After the primary insurance has paid benefits, then submit this claim form along with all EOB's (explanation of benefits) from the primary insurance.

## **Policies With Primary Coverage**

Eligible covered expenses will be paid regardless of other valid and collectible insurance or medical payment plan. There is no need to submit claim to any other insurance.

## **Deductible**

If the claimant is paying the deductible prior to submitting any claims for adjudication, please complete the back of this form. This will ensure we will be able to credit the appropriate charges to the deductible. Please be aware, although every effort will be made to match your requests, charges that have been reduced due to discounts, reasonable and customary guidelines, or plan maximums may not be credited towards the deductible.

## **Claim Form**

This Company claim form must be submitted for each individual claim. Part (A) must be completed in full by the Policyholder official or a staff member and signed by the Policyholder official or staff member. Part (B) must be completed in full by the injured person or the parent or guardian if that injured person is a minor and also must be signed. A fully completed claim form is not necessary when submitting additional medical bills, only one claim form is needed per accident/injury.

## **Medical Bills**

Attach all medical bills. All submitted medical bills must be itemized for service. A balance due statement is not acceptable and will only delay processing. A physician's office should submit an invoice per HCFA 1500. A hospital and/or emergency room should submit an invoice per UB92. HCFA 1500 and UB92 are universal billing forms supplied by the physician's office and/or hospital.

## **Information Requests**

In the event that a claim is not submitted in full or if additional information is needed, the claim will be closed, and the additional information will be requested via US Mail. Please forward the requested information immediately, so that we may finish adjudicating your claim in a swift manner. The explanation of benefits (information request) will be sent to the address of the injured person listed on the claim form in Part (B).

## **Claim Submission Checklist**

Use the below checklist to assure a properly submitted medical claim is to be sent.

*If the injured person has primary health insurance has the claim been submitted first to the primary?*

*If claim has first been submitted to the primary; are copies of EOB's (explanation of benefits) attached?*

*Is part (A) of the claim form completed by the Policyholder official or staff member and signed?*

*Is part (B) of the claim form completed by the injured person and signed?*

*Are the attached medical bills itemized in either a HCFA 1500 or UB92 form?*

*Is part (B), item number 3 (social security number) completed?*

**Mailing The Claim**

When completed in full, mail the attached completed claim form, itemized medical bills and copies of EOB's (explanation of benefits for use if coverage is excess) to:

Special Risk Accident Medical Claims  
1776 South Naperville Road, Bldg-B  
Wheaton, IL. 60187

If you should have any questions, or if a physician's office or hospital needs to confirm benefits before a medical procedure, please contact the claims office at (888) 585-7065 or (800) 782-0392.

Documents may also be faxed to the claims office at (630) 665-7294. Please do not fax full medical claims, as often times medical bills are illegible when faxed.

PLEASE NOTE, claim forms should NOT be submitted prior to claims being incurred. Please submit the claim form at the time the itemized bills and explanations of benefits are available for reimbursement.

**ACCIDENT DEDUCTIBLE CREDIT SHEET**

INJURED'S NAME \_\_\_\_\_

POLICYHOLDER'S NAME \_\_\_\_\_

DATE OF INURY \_\_\_\_\_

**NAME & ADDRESS CHECK SHOULD BE SENT TO:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PROVIDER	DATE OF SERVICE	\$ AMOUNT APPLIED TO DEDUCTIBLE
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____

*If the claimant is paying the deductible prior to submitting any claims for adjudication, please complete this form. This will ensure we will be able to credit the appropriate charges to the deductible. Please be aware, although every effort will be made to match your requests, charges that have been reduced due to discounts, reasonable and customary guidelines, or plan maximums may not be credited towards the deductible.*

# NOTICE

**WARNING:** 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 may be guilty of a crime and may be subjected to civil fines and criminal penalties. California Residents: 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 loss is guilty of a crime and may be subject to fines and confinement in state prison."

<b>PART A – This PART MUST be completed, dated and signed by an official or the Organization.</b>			
1. Name of Organization (Policyholder)			
2. Policy No.			
3. Name of Organization or Team (if Different from Policyholder)			
4. Address of Organization (Zip)		(Street)	(City) (State)
5. Name of Injured Person (Insured)		(First)	(Middle) (Last)
6. Date of Accident/Injury Mo.    Day    Year /    /	7. Injury Occurred: Practice <input type="checkbox"/> Travel <input type="checkbox"/> Game <input type="checkbox"/> Other _____		8. Type of Sport or Activity:
9. Explain HOW the accident and injury occurred. NOTE: If your organization uses an Accident Report, attach a copy of the Report.			
10. Describe the nature of injury.			
11. At the time of the accident, was the Person involved in an activity under the jurisdiction of the Organization (Policyholder)? Yes <input type="checkbox"/> No <input type="checkbox"/>	12. Name of Supervisor of Activity		13. Was he/she a witness to the injury? Yes <input type="checkbox"/> No <input type="checkbox"/>
14. Signature of Organization Official  <b>X</b> _____	15. Title of Official	16. Area Code/Telephone No.  (    )	17. Date Signed

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

PRINT HERE – NAME OF PERSON COMPLETING FORM  
Guardian \_\_\_\_\_

Circle One: Injured Person  Parent

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. ( )
-------------------------------------	---	---	-----------------------------------

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

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

Area Code/Telephone No.  
( )

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

Name of other Policyholder(s) Insurance Company(s)	Address of Other Insurance Company(s)	Policy Number(s)	Name of
--	--	------------------	---------

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 Employer  
Address of Employer ( ) Area Code/Employer Phone No.

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

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

Name of Spouse 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 to diagnosis, treatment, and prognosis regarding any physical, mental, drug or alcohol condition of any and all such information to be given to the Society of Underwriters at Lloyds, London 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 I or my authorized representative will receive a copy of this authorization upon request.

**X** \_\_\_\_\_  Injured Person  
Signature (in writing) of Responsible Party Print Name Circle one:  Parent Date: \_\_\_\_\_  
 Guardian