STUDENT ACCIDENT INSURANCE CLAIM REPORT

THIS FORM MUST BE COMPLETED AND SUBMITTED TO THE COMPANY WITHIN 90 DAYS FROM DATE OF ACCIDENT. MEDICAL TREATMENT MUST COMMENCE WITHIN 30 DAYS FROM DATE OF ACCIDENT.

IMPORTANT NOTICE: The student accident insurance plan is designed to offer maximum financial protection at a minimum cost. In order to maintain this balance of cost and adequate protection, the plan does not allow us to provide benefits for certain losses that are collectible from your personal insurance. This provision has greatly reduced the cost to you by not duplicating coverage that you already have in effect. Please attach a statement from your insurance company indicating what benefits are available and complete the following questions.

INSTRUCTIONS:

1. If accident occurred during a school activity a school official must complete PART 1-A. 2. The insured's parents or guardian must complete PART 1-B; (also PART 1-A if accident was not school related). 3. Send completed claim form with all itemized bills to:

LAWRENCE E. SMITH & ASSOCIATES, Box 411216, St. Louis, Missouri 63141 (636)532-1660 or 1-800-325-1350

IF PART 1-A, PART 1-B & PART II ARE NOT COMPLETED **IN FULL** THIS CLAIM CANNOT BE PROCESSED AND WILL BE RETURNED.

PART 1-A: SCHOOL AND PARENT

(Please type or print)

(1) School District ______________________ (2) School ______________________

(2) School Address ______________________ (4) School Phone No. ______________________

(5) Student ______________________ (6) Student's Social Security No. ______________________

(Last name) (First Name)

(7) Grade ________ (8) Birthdate ______________ (9) ☐ Male ☐ Female (10) Date of Accident ________ (11) Time ________

(12) Where did the accident happen? ______________________

(13) **Specifically** – what happened? ______________________

(14) Part of the body injured ______________________ (15) Type of sport ______________________

(16) At the time of injury was the student involved in a school sponsored and supervised activity? ☐ Yes ☐ No ☐ Other ______________

If yes, was student a: ☐ participant ☐ spectator

(17) If athletics, designate: ☐ P.E. Class ☐ Intramural ☐ Interscholastic ☐ Practice ☐ Game

(18) Under whose supervision? ______________________ Was he/she a witness? ☐ Yes ☐ No

(19) ______________________ ______________ ______________

School Official Signature (Unable to process without a school official signature) Title Date

PART 1-B: PARENT OR GUARDIAN STATEMENT

(20) Father's Name ______________________ Social Security No. ______________________

(21) Mother's Name ______________________ Social Security No. ______________________

(22) Home Address ______________________

(Street/P.O. Box) (City) (State) (Zip) (Home Phone No.)

(23) Father's Occupation ______________ Employer ______________ Tel.# ______________

(24) Employer's Address ______________________

(25) Name and Address of Insurance Company ______________________

(26) Policy No. ______________ Co. Tele. ______________ ☐ Group ☐ Individual ☐ Other ☐ No other insurance

(27) Mother's Occupation ______________ Employer ______________ Tel# ______________

(28) Employer's Address ______________________

(29) Name and Address of Insurance Company ______________________

(30) Policy No. ______________ Co. Tele. ______________ ☐ Group ☐ Individual ☐ Other ☐ No other insurance

(31) Name and address of places where treatment was received:

Doctors: ______________________

Hospitals: ______________________

Do you understand that you must furnish, with this claim, a statement from your primary insurance company indicating their allowable benefits or their reason for refusal to pay? Your claim will be held pending receipt of this information. ☐ Yes ☐ No

DELAWARE REQUIRED STATEMENT: *Any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.* **OHIO REQUIRED STATEMENT:** *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.* **COLORADO REQUIRED STATEMENT:** 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 CO Div. of Insurance within the Department of Regulatory Agencies. **AFFIDAVIT:** *I certify that the above information is true and correct. I AUTHORIZE any doctor, medical practitioner, hospital, clinic, other medical or medically related facility or insurance company, or other organization, institution, or person that has any record or knowledge of: a) the claimant's physical or mental health or: b) benefits for which the claimant may be entitled to for this claim; to give the information to the insurance company to facilitate rapid submission for such information. I authorize all said sources, to give such records or knowledge to any agency employed by the insurance company to collect and transmit such information. I understand that false or incomplete information will prolong claim benefit determination. A photocopy of this authorization shall be as valid as the original.*

SIGNATURE ______________________ Date ______________

(Parent or Guardian)

L. E. SMITH & ASSOC., INC., PLAN ADMINISTRATOR

ATTENDING PHYSICIAN'S STATEMENT ON REVERSE SIDE

HEALTH INSURANCE CLAIM – GROUP OR INDIVIDUAL

Patient's Name	Address	City, State, Zip	Age

PART II: ATTENDING PHYSICIAN'S STATEMENT

1. Diagnosis and concurrent conditions. Describe any complications.

2. When did symptoms first appear or accident happen? Date ______

3. When did patient first consult you for this condition? Date ______

4. Has patient ever had same or similar condition? If yes, state when and describe. No ☐ Yes ☐ Date ______

5. Describe any other disease or infirmity affecting present condition.

6. If fracture or dislocation, state whether reduced or immobilized. If immobilized, explain procedure. Fee $ ______
   CPT/CRVS ______

7. Name of surgical procedure. Describe fully. Include CPT/CRVS Code. Where and when performed? Fee $ ______
   CPT/CRVS ______ Date ______ Office ☐ If in hospital, inpatient ☐ outpatient ☐

8. Give dates of other medical (non-surgical) treatment, if any. Describe.

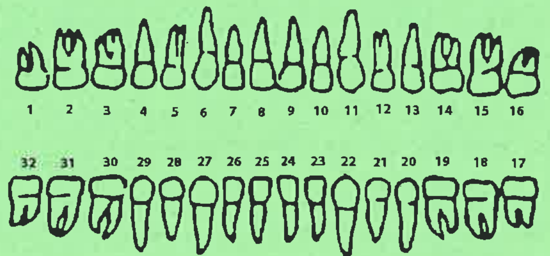
	CHARGE PER CALL
Office ______	$ ______
Office ______	$ ______
Hospital ______	$ ______
Hospital ______	$ ______
TOTAL (NON SURGICAL) CHARGES	$ ______

9. If patient hospitalized, give name and address of hospital. Date admitted ______ Date discharged ______
   Hospital ______ City ______ State ______

10. To your knowledge does patient have other health insurance or health plan coverage? If "Yes", identify. No ☐ Yes ☐
    Name ______ Address ______

If Dentistry, answer all questions below, in addition to those above.

1. State exactly which teeth were involved in the accident and indicate them on chart.



2. Describe exact nature of injury ______

3. **Describe condition of injured teeth prior to accident:**
   ☐ Whole, sound and natural ☐ Filled ☐ Capped/Artificial ☐ Caries

4. Comments ______

Physician or Supplier's Name	Degree
Street Address	TIN #
City State Zip	Date
Telephone	Signature

IMPORTANT: This form MUST be completed and returned WITHIN 90 DAYS from the date of treatment, accompanied by all bills incurred to that date.