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SCHOLASTIC INSURORS, INC.
P. O. Box 3194, Johnson City, TN 37602-3194

GROUP ALL SCHOOL INSURANCE CLAIM FORM

PLEASE READ CAREFULLY

CLAIM PROCESSING

*** * See Reverse side * ***

PART A
SCHOOL OFFICIAL TO COMPLETE

1) Name of School_____Name of School System_____
School Address_____
(City) (State) (Zip)

2. Name of Injured Student (Print)_____ Grade____ Age_____
(First) (Middle) (Last)

3. Date of Injury_____ Time of Injury _____

4. Under whose supervision?_____ Title_____

5. The accident was incurred while the student was participating in:
(check one) _____ Game _____ Practice _____ P.E. _____Travel _____ Other

6. At the time of the injury, was the student involved in a school sponsored and supervised activity? ____yes _____ no

7. Describe the accident fully. How did the accident happen?

_____

_____

Reported by:_____
(Signature of School Official) (Title) (Date)

PART B: PARENT/GUARDIAN STATEMENT

FATHER or GUARDIAN

Full Name_____S.S.#_____

Address_____
(street)

_____
(city) (state) (zip)

Occupation_____ Employer_____

Employer Address_____
(street)

_____
(city) (state) (zip)

Name & Address of Other Insurance Company_____

_____

Policy/Group No._____
Group Individual HMO/PPO

MOTHER or GUARDIAN

Full Name_____S.S.#_____

Address_____
(street)

_____
(city) (state) (zip)

Occupation_____ Employer_____

Employer Address_____
(street)

_____
(city) (state) (zip)

Name & Address of Other Insurance Company_____

_____

Policy/Group No._____
Group Individual HMO/PPO

KENTUCKY REQUIRED STATEMENT: 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.

1. **I understand that I must furnish, with this claim, a statement from my personal insurance company indicating their allowable benefits or their reason for refusal to pay. I further understand this claim will remain pending until this information is provided.**
2. I hereby authorize Reliance Standard Life Insurance Company to pay benefits (as provided by the policy) in connection with this accident direct to the doctor , and/or hospital rendering service unless I have checked below.
_____ I do not authorize an assignment and request that benefits be paid directly to me.
3. I hereby authorize any insurance company, hospital, physician. or other person who has attended or examined the claimant to disclose when requested to do so by Reliance Standard Life Insurance Company, or its representative, any and all information with respect to any injury, policy coverage, medical history, consultation, prescription or treatment and copies of all hospital or medical records. A photostatic copy of this authorization shall be considered as effective and valid as the original.
4. I understand that I shall have a free choice of a physician or hospital for treatment. If, however, there is other valid coverage through another insurance plan and I do not choose a physician or hospital through the other plan, Reliance Standard Life will pay benefits as if the other plan's guidelines had been followed.
5. I certify that I have read and understand items 1– 4 (above) and I have read and understand the information on the reverse side of this form.

_____ _____
(Date) (Signature of Parent or Guardian)

PART C: FOR DENTAL INJURY

To be completed by dentist in the event of injury involving treatment to one or more teeth. Not to be used as a replacement for a copy of the actual itemized charges.

1. Identify injured teeth by tooth No._____
2. Previous condition of injured teeth: Whole, sound, natural; Filled; Decayed; Root canal treated; Other (describe)_____

(Date)_____Dentist's Name (Print)_____Dentist's Signature_____

FA&AS-B

NOTE: *PLEASE READ THIS <u>BEFORE</u> SUBMITTING A CLAIM*

INSTRUCTIONS FOR FILLING OUT THIS CLAIM FORM

IMPORTANT!!!

- Treatment Must Begin Within 30 Days From Date Of Accident
- Completed Claim Form Must Be Submitted Within One (1) Year From Date Of Accident
- All Treatment Must Be Received Within One (1) Year Of Accident

NOTE: *TO SCHOOL PERSONNEL AND PARENTS*

Our objective at Scholastic Insurors is to provide fast and accurate claims service. Listed below are instructions that, when followed, will assist us in providing this service.

WHEN *TO FILE A CLAIM*

1. **Since the policy contains an EXCESS MEDICAL EXPENSE BENEFIT, YOU MUST FIRST FILE THE CLAIM WITH ANY OTHER INSURANCE (including major medical, HMO, PPO, CHAMPUS, etc.) so we may determine what payments, if any, we owe. ***

2. **The completed claim form and supporting documents must be received by Scholastic Insurors within one (1) year after the date of accident.**

HOW *TO FILE A CLAIM*

1. **Part A and Part B <u>must be completed in full</u>.**

2. **In the event the claimant sustained a dental injury, Part C <u>must be completed in full</u> by the dentist providing treatment.**

3. **Attach itemized bills showing the: (a) name of patient, (b) diagnosed condition, (c) date(s) of treatment, (d) nature of treatment, and (e) charge per treatment.**

4. **SINCE THE POLICY CONTAINS AN EXCESS MEDICAL EXPENSE BENEFIT, we also need:**
   - **A. Statement(s) from the other insurance company(ies) or plan(s) showing the payment(s) or rejection of the claim; or**
   - **B. If the insured has no coverage, a written statement from the insured's parent's employer(s) verifying there is no coverage for the insured.**

WHERE *TO FILE A CLAIM*

Send all completed forms, itemized medical bills, etc., to:

SCHOLASTIC INSURORS, INC.
P.O. BOX 3194
JOHNSON CITY, TN 37602-3194
Telephone: 423-928-7381 Fax: 423-928-2761

The insured shall have free choice of a physician or hospital for treatment. If, however, an insured has other valid coverage through another insurance plan(s) and does not choose a physician or hospital through the other plan, we will pay benefits as if the other plan's guidelines had been followed.