FORT THOMAS
INDEPENDENT SCHOOLS

HIGHLANDS HIGH
HIGHLANDS MIDDLE
JOHNSON ELEMENTARY
MOYER ELEMENTARY
WOODFILL ELEMENTARY

Rich in Tradition Focused on the Future

July 1, 2018

To whom it may concern:

We are sorry that your son or daughter was recently injured during a school activity. The purpose of this packet is to educate you about the Student Accident Insurance coverage that Fort Thomas Independent Schools maintains on all of our students during the school year. It is our intent to make sure that you have as much information regarding this insurance as possible and to insure that you have all the necessary forms required to initiate a claim and submit the items for payment. The Student Accident Insurance maintained by the District is supplemental insurance, but it can be primary insurance if the student is not covered by any other insurance policy. The District has obtained coverage from Health Special Risk, Inc. Please read the attached information carefully.

Included in this packet is the following information:

1) Instructions for filing a claim
2) Claim Form

Our local representative for this policy is Gross Insurance. If, at any point in this process, you have questions regarding your claim or this process, please contact Paula Arthur at Gross Insurance for assistance. Paula can be reached at 859-445-0416 or via email at paula.arthur@gross-ins.com.

Sincerely,

Jerry Wissman

Jerry Wissman
Director of Operations
Fort Thomas Independent Schools

28 NORTH FORT THOMAS AVENUE | FORT THOMAS, KENTUCKY 41075-1555
859.781.3333 ph | 859.442.4016 fx | WWW.FORTTHOMAS.KYSCHOOLS.US

Claim Processing Procedures

1. Claim forms are provided to the district for distribution.

2. The Claim Form must be completed in its entirety and signed by both parents and a school official.

3. The date of the accident and a detailed description are required to verify that the incident occurred while participating in a school sponsored and supervised activity.

4. The claim form should be submitted to the carrier within 60 days of the accident. The address and phone number for the location that processes the claims is listed on the claim form.

5. In addition to the claim form, the company will also require the following in order to make payment:

    - Itemized physician, hospital, or other provider bill that includes the diagnostic and procedure codes
      NOTE: For hospital charges, a Form UB04 is required. For physician/ancillary charges, a Form CMS1500 is required.
    - Explanation of Benefits from primary carrier

For questions regarding claims, a toll free number is provided on the claim form for easy reference.

In the event an issue should arise with a specific claim, Roberts Insurance & Investments can be reached from 8:30 – 5:00 EST Monday-Friday to assist. Please contact Bobbi Land or Stephanie Branham at (859) 623-7684 or 1-877-757-2581. They can also be reached by email at bobbi@bobrobertsins.com or stephanie@bobrobertsins.com.

HSR
Health Special Risk, Inc.

P.O. Box 117558
Carrollton, Texas 75011-7558
Phone: (972) 512-5600 Fax: (972) 512-5818
Toll Free (866) 243-7885

School District: _____

City and State: _____

School Name: _____

Policy Number: _____

. JDENT CLAIM FORM

1. Please fully complete this form
2. Attach itemized bills
3. Mail to *HSR*

* *DENOTES REQUIRED INFORMATION*

PART I – POLICYHOLDER'S REPORT

1.* Claimant's Name (injured/ill person)	2.* Social Security Number	3.* Gender ☐M ☐F	4.* Date of Birth	5. E-Mail
6.* Address of Injured Person	* City	* State	* Zip	7. Phone Number
8.* Parent's Name & Address	* City	* State	* Zip	9. Parent's Phone Number
10.* Date of Accident/Illness	11. Time of Accident ☐a.m. ☐p.m.	12.* Place where Accident Occurred		13.* Date of First Treatment
Dental Claims	14.* Indicate which Teeth were Involved in the Accident	15.* Describe Condition of Injured Teeth Prior to Accident: ☐ Whole, Sound, and Natural ☐ Filled ☐ Capped ☐ Artificial		

16.* Type of Injury (Indicate Part of Body Injured – e.g. broken arm, sprained ankle, etc.) Did Injury Result in Death? ☐Yes ☐No

17.* Describe How Accident Occurred or the Nature of the Illness – Give all possible details

18.* Which Best Describes the Activity:

☐ Play or practice of interscholastic sports
☐ Not school related
☐ P.E. class
☐ During lunch hour
☐ In school bus
☐ School sponsored field trip
☐ Traveling to/from school
☐ Athletic period
☐ On school property during school hours
☐ School sponsored activity during school hours
☐ A spectator

19.* Name of Person Supervising the Activity

20.* If engaged in an Interscholastic Sport at the time of the injury, what was the sport?

gnature of Parent/Legal Guardian:
X Date:

* Signature of School Official:
X Date:

* PART II – OTHER INSURANCE STATEMENT

Do you/spouse/parent have medical/health care or is the Claimant enrolled as an individual, employee or dependent member of a Health Maintenance Organization (HMO) or similar prepaid health care plan, or any other type of accident/health/sickness plan coverage through your employer or other source on you or, if applicable, does your son/daughter have health care coverage as a dependent from your previous marriage as mandated in a divorce decree? ☐ Yes ☐ No

If Yes, name of insurance company _____ Policy # _____

Name of insurance company _____ Policy # _____

If applicable, claimant's primary employer name, address, and phone number _____

If applicable, mother's primary employer name, address, and phone number _____

If applicable, father's primary employer name, address, and phone number _____

IF OTHER INSURANCE OR HEALTH CARE PLANS EXIST, PLEASE SUBMIT COPIES of their EXPLANATION OF BENEFITS along with your claim.
IF NO OTHER INSURANCE or HEALTH PLAN EXISTS, PLEASE READ & SIGN BELOW.
I agree that should it be determined at a later date there is insurance (or similar), to reimburse *HEALTH SPECIAL RISK, INC.*, or the insurance company to the extent of any amount collectible.

Signature of Parent/Legal Guardian:
X Date:

Signature of Witness:
X Date:

* PART III – AUTHORIZATION TO PAY BENEFITS TO PROVIDER

I hereby authorize medical payments to be made directly to doctor(s), hospital(s), or indicated provider(s) of service(s) in connection with this claim.

(Otherwise submit proof of payment)

ATURE _____ DATE _____

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, all information with respect to any injury, policy coverage, medical history, consultation, prescription or treatment, and copies of all hospital or medical records. A photo static copy of this authorization shall be considered as effective and valid as the original.

SIGNATURE _____ DATE _____

FRAUD STATEMENTS

RESIDENTS OF ALL STATES OTHER THAN THOSE LISTED BELOW:

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 fines and confinement in prison.

Alaska and Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false, incomplete or misleading information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and may be prosecuted under state law.

Arizona: 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.

Arkansas, Louisiana, Maryland, West Virginia &Rhode Island : 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 is guilty of a crime and may be subject to fines and confinement in prison.

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

Colorado: 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.

Connecticut: This form must be completed in its entirety. Any person who intentionally misrepresents or intentionally fails to disclose any material fact related to a claimed injury may be guilty of a felony.

Delaware, Idaho, 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.

District of Columbia: Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida: WARNING :Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Hawaii: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

Georgia: Any natural person who knowingly or willfully

1) Makes or aids in the making of any false or fraudulent statement or representation of any material fact or thing:
   a) In any written statement;
   b) In the filing of a claim; or
   c) In the receiving of money for an application for a policy of insurance for the purpose of procuring or attempting to procure the payment of any false or fraudulent claim or other benefit by an insurer;
2) Receives money for the purpose of purchasing insurance and converts such money to such persons own benefit;
3) Issues fake or counterfeit insurance policies, certificates of insurance, insurance identification cards, or insurance binders; or
4) Makes any false or fraudulent representation as to the death or disability of a policy or certificate holder in any written statement for the purpose of fraudulently obtaining money or benefit from an insurer commits the crime of insurance fraud.

Maine: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or a denial of insurance benefits.

Michigan, North Dakota, South Dakota: Any person who knowingly and with intent to defraud any insurance company or another 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, and subjects the person to criminal and civil penalties.

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

Nevada: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under state or federal law, or both, and may be subject to civil penalties.

New Hampshire: 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.

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

New Mexico and Pennsylvania: 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.

New York: 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.

Ohio: 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.

Oklahoma: 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.

Oregon: Warning: Any person who knowingly, and with intent to defraud any insurance company or other persons files an application for insurance or statement of containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, may be subject to prosecution for insurance fraud.

Tennessee, Virginia, Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Texas: Any person who knowingly presents a 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.

Listed below are important instructions and comments about filing a claim.

YOUR CLAIM FORM

1. This claim form should be fully completed and submitted within 90 days from the date of injury. Be sure to answer and complete the section regarding "OTHER INSURANCE STATEMENT", marking either yes or no, and signing the line for authorization, so that *HSR* and the doctors/hospital may communicate concerning your claim.
   Incomplete claim forms are one of the most frequent reasons why claim payments are delayed.
2. Only one claim form for each accident needs to be submitted.
3. Once completed, make a photocopy for your records, and mail to the address shown below.
4. DO NOT assume that anyone else will mail this claim form to *HSR* for you.

YOUR BILLS

1. Please advise all doctors/hospitals regarding this coverage so they may forward us their itemized bills.
2. If you have already been to the doctor/hospital and did not know about this coverage, then please send all of the itemized bills to *HSR* at the address shown below.
3. The bills should include the name of the doctor/hospital, their complete mailing address, telephone number, the date you were seen by the doctor/hospital, what the doctor saw you for (diagnosis) and the specific itemized charges (description of treatment and amount) incurred (including the CPT/procedure code).
4. If this information is not on the bill when you send this in we will have to contact the doctor/hospital which will delay the review of your claim. "Balance Due" or "Balance Forward" statements do not contain sufficient information to complete your claim.

EXCESS INSURANCE (if applicable)

1. This policy may provide coverage on a secondary/excess basis. If you have any primary insurance coverage, you need to send the bills to your primary insurance first.
2. *HSR* will consider benefits after your other, primary, insurance has processed the claim.
3. We will require a copy of your primary insurance Explanation of Benefits (EOB) which you should receive from your primary insurance letting you know what was paid or denied, and the reason(s) why.
4. *HSR* will not be able to consider your claim without this information.

If you have any questions, please contact Customer Service at (866) 409-5734. They are available from 8:00 a.m. thru 6:00 p.m. central time, Monday – Friday. You may also forward any documents by fax to (972) 512-5818.

Health Special Risk, Inc.
P.O. Box 117558
Carrollton, TX 75011-7558