Cobertura del seguro de accidentes para estudiantes
2020-2021 Año escolar

Nuestro distrito escolar proporcionará a todos los estudiantes matriculados (Pre-K a 12 ° Grado) una póliza de seguro de accidentes estudiantiles en exceso a través de Gerber Life Insurance Company. El seguro de accidentes para estudiantes proporciona cobertura durante las horas y días en que la escuela está en sesión, mientras participa en actividades patrocinadas y supervisadas por la escuela. La cobertura incluye la participación en deportes interescolares; incluyendo fútbol, clases de educación religiosa, excursiones de un día y excursiones de una noche * (no más de 7 noches consecutivas). Esto incluye viajar directamente (ininterrumpidamente) hacia y desde una actividad programada regularmente con otros miembros como grupo. El viaje debe ser supervisado por una persona autorizada por la escuela.

Horario de beneficios:

Beneficio máximo $ 25,000
Deducible $ 250
Coseguro Ninguno

paciente interno

Habitación y comida:	100% de los cargos usuales y habituales
cuidados intensivos:	100% de los cargos usuales y habituales
hospital misceláneo:	100% de los cargos usuales y habituales
Cirugía:	100% de los cargos usuales y habituales en base a los datos proporcionados por ingenix, en el percentil 80
Cirujano asistente:	100% de los cargos usuales y habituales
Anestesista:	100% de los cargos usuales y habituales
enfermera registrada:	100% de los cargos usuales y habituales
visitas del medico:	100% de los cargos usuales y habituales

paciente externo

Cirugía:	100% de los cargos usuales y habituales en base a los datos proporcionados por ingenix, en el percentil 80
cirugía diurna varios	100% de los cargos usuales y habituales (los cargos usuales y habituales para la cirugía diaria se basan en el índice de cargo de la instalación quirúrgica para pacientes ambulatorios)
Cirujano asistente:	100% de los cargos usuales y habituales
Anestesista:	100% de los cargos usuales y habituales
beneficio misceláneo	100% de los cargos usuales y habituales
para pacientes ambulatorios:	100% de los cargos usuales y habituales
visitas del medico:	100% de los cargos usuales y habituales
fisioterapia:	100% de los cargos usuales y habituales
Emergencia médica:	100% de los cargos usuales y habituales

radiografías de diagnóstico:	100% de los cargos usuales y habituales
laboratorio:	100% de los cargos usuales y habituales
pruebas y procedimientos:	100% de los cargos usuales y habituales

Otro

Ambulancia:	100% de los cargos usuales y habituales
Equipo médico duradero:	100% de los cargos usuales y habituales
Dental:	(beneficios pagados por lesiones a dientes sanos y naturales solamente) 100% de los cargos usuales y habituales

Reemplazo de anteojos, audífonos o lentes de contacto dañados durante una lesión cubierta, si también se recibe tratamiento médico por la lesión cubierta.
100% de los cargos usuales y habituales
Esto es lo más destacado de los beneficios y los pagos de reclamaciones están sujetos al plazo de la póliza.

Cómo se pagan los beneficios
(Exceso de cobertura)

Exceso de cobertura. Si una lesión a la persona asegurada resulta en incurrir en gastos médicos cubiertos por cualquiera de los servicios especificados en el cronograma de beneficios, la compañía pagará los gastos médicos cubiertos incurridos sujeto al monto del deducible y porcentaje de coseguro (si corresponde), que están en exceso de gastos médicos cubiertos pagaderos por otro seguro válido y cobrable.

Los gastos médicos cubiertos excluyen los montos no cubiertos por el portador principal debido a las penalizaciones impuestas al asegurado por no cumplir con las disposiciones o requisitos de la póliza.

Aviso de reclamo

Se debe entregar un aviso por escrito de la reclamación a la compañía dentro de los 90 días posteriores a la ocurrencia o al comienzo de cualquier pérdida cubierta por esta política, o tan pronto como sea razonablemente posible. El aviso dado por o en nombre del asegurado nombrado a la compañía, con información suficiente para identificar al asegurado nombrado se considerará aviso a la compañía. Se debe presentar un comprobante de pérdida por escrito a la compañía en dicha oficina dentro de los 90 días posteriores a la fecha de dicha pérdida. El tratamiento debe comenzar 180 días después de la fecha de la lesión y se recibió dentro de los 12 meses posteriores a la fecha de la lesión.

En caso de accidente, los estudiantes deben:

1. Asegure el tratamiento en la instalación médica más cercana de su elección.
2. Obtenga un recibo (si se hicieron pagos) y una copia detallada de los cargos del proveedor de servicios médicos y envíe copias de sus facturas detalladas, explicación de beneficios del seguro primario y el formulario de reclamo de accidente completamente completado y firmado a los reclamos office-mail toda la correspondencia a WEB_TPA, PO Box 2415, Grapevine, TX 76099-2415.
3. **Llame al 1-866-975-9468, Política # 28-3767-18** con cualquier pregunta sobre reclamos.

PLEASE READ THIS INFORMATION CAREFULLY. It is important.

PLEASE FOLLOW THESE INSTRUCTIONS TO FILE A CLAIM

ALL INFORMATION MUST BE PROVIDED IN ORDER FOR CLAIM TO BE PROCESSED. PROCESSING OF YOUR CLAIM WILL BE DELAYED IF COMPLETE INFORMATION IS NOT RECEIVED

NOTE: The accident policy benefits are limited and may not provide 100% coverage. Accident medical expense coverage under this policy is provided on an Excess Basis, and in most instances, benefits will only be paid under this plan after your own personal or group insurance has paid out its benefits. Completion of a claim form does not guarantee benefit payment. Each claim is reviewed according to the policy provisions.

Claim Guidelines: The following guidelines must be followed.

♦Answer all questions in detail (including all signatures on the front and back of the form). A claim form needs to be completed for each accident.

♦If you have other insurance, submit your claim to your other insurer. When you receive the explanation of benefits (sample attached) notice from your primary carrier, send it to us along with the corresponding HCFA/UB04 medical bills and with the fully completed claim form. You must submit the provider's medical bills; balance due statements will not be processed. Medical bills must include the procedure & diagnosis code along with the Provider's federal identification number. These bills are:

1) HCFA-1500 (standard form used by Providers; sample attached)
2) UB-04 or UB-92 (standard form used by Hospitals sample attached)
3) ADA Dental Claim Form and a letter from the dentist verifying the injured tooth was whole, sound and natural. (All dental bills must be submitted through your primary insurance's medical and dental plans first before submitting the bills to WebTPA)

It would be helpful if the following was given to all providers the injured person is seeking treatment from:

1. WebTPA contact information
2. Organization/School name found on the claim form
3. Policy number found on the claim form

This way the providers of service can work directly with the claim office and provide them with the correct billing forms (itemized bill to include procedure & diagnosis code and tax id number) needed to process a claim.

♦If you already paid the medical bill, include a paid receipt or a copy of your cancelled check at the same time you submit the medical bill. Otherwise payment will be made to the providers of service (Hospital, Physician or Others).

♦Send all correspondence to WebTPA, Inc., **P.O. Box 2415 Grapevine, TX 76099-2415**. The claim form must be sent within 90 days of the date you first received medical care. Any bills not filed with the claim form should be sent, within 90 days of the date you received medical care, to the Company identified with claimant's name, Organization or School name and date of Accident.

♦If you change your address, please notify WebTPA, Inc. by sending notification to WebTPA so that there is no delay in processing any claims.

♦Please contact WebTPA, Inc. by calling **866-975-9468** if you would like to check the status of your claim or if you have any questions on how your claim was processed or the benefit paid.

Common Causes For Delays In Processing Claims

1. Claim Forms Not Completed In Full or Not Submitted.
2. Balance Due, Balance Forward, or Past Due Statements Submitted for Bills.
3. Explanation of Benefits from Primary Carrier Not Provided with the Bills.

KEEP COPIES OF ALL CLAIM FORMS, MEDICAL BILLS, AND CORRESPONDENCE FOR YOUR OWN RECORDS UNTIL YOUR CLAIM HAS BEEN PROCESSED.

SAMPLE HCFA 1500

PLEASE DO NOT STAPLE IN THIS AREA

APPROVED OMB-0938-0008

CARRIER

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE / MEDICAID / CHAMPUS / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER — (Medicare #) (Medicaid #) (Sponsor's SSN) (VA File #) (SSN or ID) (SSN) (ID)
1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
3. PATIENT'S BIRTH DATE MM DD YY — SEX M F
4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)
6. PATIENT RELATIONSHIP TO INSURED — Self, Spouse, Child, Other
7. INSURED'S ADDRESS (No., Street)
CITY — STATE
8. PATIENT STATUS — Single, Married, Other; Employed, Full-Time Student, Part-Time Student
CITY — STATE
ZIP CODE — TELEPHONE (Include Area Code)
ZIP CODE — TELEPHONE (INCLUDE AREA CODE)
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)
10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER
a. EMPLOYMENT? (CURRENT OR PREVIOUS) — YES NO
a. INSURED'S DATE OF BIRTH MM DD YY — SEX M F
b. OTHER INSURED'S DATE OF BIRTH MM DD YY — SEX M F
b. AUTO ACCIDENT? — PLACE (State) — YES NO
b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME
c. OTHER ACCIDENT? — YES NO
c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME
10d. RESERVED FOR LOCAL USE
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? — YES NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE
SIGNED — DATE
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE
SIGNED
14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)
15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION — FROM — TO
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE
17a. I.D. NUMBER OF REFERRING PHYSICIAN
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES — FROM — TO
19. RESERVED FOR LOCAL USE
20. OUTSIDE LAB? — $ CHARGES — YES NO
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
22. MEDICAID RESUBMISSION CODE — ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1										
2										
3										
4										
5										
6										

25. FEDERAL TAX I.D. NUMBER — SSN EIN
26. PATIENT'S ACCOUNT NO.
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) — YES NO
28. TOTAL CHARGE $
29. AMOUNT PAID $
30. BALANCE DUE $
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
SIGNED — DATE
32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)
33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
PIN# — GRP#

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

SAMPLE UB-04

PAGE — OF — CREATION DATE — TOTALS

SAMPLE ADA DENTAL CLAIM FORM

American Dental Association Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)
[X] Statement of Actual Services — [ ] Request for Predetermination/Preauthorization
[ ] EPSDT/Title XIX

2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code
Insurance Company Name
Address 1
Address 2
City ST ZIP

OTHER COVERAGE

4. Other Dental or Medical Coverage? [ ] No (Skip 5-11) [ ] Yes (Complete 5-11)
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)
6. Date of Birth (MM/DD/CCYY)
7. Gender [ ] M [ ] F
8. Policyholder/Subscriber ID (SSN or ID#)
9. Plan/Group Number
10. Patient's Relationship to Person Named in #5 [ ] Self [ ] Spouse [ ] Dependent [ ] Other
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code
Other Insurance Company Name
Address
City ST ZIP

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
Policyholder Name
Address 1
Address 2
City ST ZIP
13. Date of Birth (MM/DD/CCYY)
14. Gender [ ] M [ ] F
15. Policyholder/Subscriber ID (SSN or ID#)
16. Plan/Group Number
17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above [ ] Self [ ] Spouse [ ] Dependent Child [ ] Other
19. Student Status [ ] FTS [ ] PTS
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
Patient Name
Address 1
Address 2
City ST ZIP
21. Date of Birth (MM/DD/CCYY)
22. Gender [ ] M [ ] F
23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description	31. Fee
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

MISSING TEETH INFORMATION

34. (Place an 'X' on each missing tooth)

Permanent: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 / 32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

Primary: A B C D E F G H I J / T S R Q P O N M L K

32. Other Fee(s)
33. Total Fee 0

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X
Patient/Guardian signature — Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X
Subscriber signature — Date

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment [ ] Provider's Office [ ] Hospital [ ] ECF [ ] Other
39. Number of Enclosures (00 to 99) Radiograph(s) Oral Image(s) Model(s)
40. Is Treatment for Orthodontics? [ ] No (Skip 41-42) [ ] Yes (Complete 41-42)
41. Date Appliance Placed (MM/DD/CCYY)
42. Months of Treatment Remaining
43. Replacement of Prosthesis? [ ] No [ ] Yes (Complete 44)
44. Date Prior Placement (MM/DD/CCYY)
45. Treatment Resulting from [ ] Occupational illness/injury [ ] Auto accident [ ] Other accident
46. Date of Accident (MM/DD/CCYY)
47. Auto Accident State

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)

48. Name, Address, City, State, Zip Code
Dentist Name
Address 1
Address 2
City ST ZIP
49. NPI
50. License Number
51. SSN or TIN
52. Phone Number ( ) -
52A. Additional Provider ID

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X
Signed (Treating Dentist) — Date

54. NPI
55. License Number
56. Address, City, State, Zip Code
Address
City ST ZIP
56A. Provider Specialty Code
57. Phone Number ( ) -
58. Additional Provider ID

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To Reorder call 1-800-947-4746

SAMPLE EOB (EXPLANATION OF BENEFITS)

UNITEDHEALTHCARE SERVICE LLC
GREENSBORO SERVICE CENTER
P O BOX 740800
ATLANTA, GA 30374-0800
PHONE: 1-800-638-8010
VISIT WWW.MYUHC.COM FOR SELF SERVICE

UnitedHealthcare
A UnitedHealth Group Company

PAGE: 1 OF 1
DATE: 04/29/10
SSN/ID #:
EMPLOYEE:
CONTRACT:
BENEFIT PLAN: PFIZER INC

EXPLANATION OF BENEFITS

SERVICE DETAIL

PATIENT/RELAT CLAIM NUMBER (1)	PROVIDER/ SERVICE	DATE OF SERVICE	AMOUNT CHARGED (2)	NOT COVERED (3)	AMOUNT ALLOWED (4)	COPAY/ DEDUCTIBLE (5)	PLAN COVERS (6)	BENEFIT AVAILABLE (7)	REMARK CODE (8)
9061512101	MEDICAL SERVICES	03/19/10	379.00	297.83	81.17		80%	64.94*	4C
		TOTAL	379.00	297.83	81.17			64.94	

MEDICARE PAID 44.64 (9)
PLAN PAYS 20.30 (10)

(*) INDICATES PAYMENT ASSIGNED TO PROVIDER

REMARK CODE(S) LISTED BELOW ARE REFERENCED IN THE "SERVICE DETAIL" SECTION UNDER THE HEADING "REMARK CODE"
(4C) THIS PLAN DETERMINES BENEFITS ONCE MEDICARE MAKES PAYMENT. IF MEDICARE PAYS LESS THAN THIS PLAN'S BENEFIT, THIS PLAN WILL CONSIDER THE DIFFERENCE. THIS PLAN'S ALLOWABLE BENEFITS ARE BASED ON THE MEDICARE APPROVED AMOUNT IF THE PHYSICIAN OR PROVIDER ACCEPTED MEDICARE'S ASSIGNMENT OR ON THE LIMITING CHARGE IF THEY DID NOT ACCEPT THE ASSIGNMENT. THE PATIENT IS RESPONSIBLE FOR THE DIFFERENCE BETWEEN THE ALLOWABLE AMOUNT AND THE TOTAL AMOUNT PAID BY BOTH PLANS. THE PATIENT MUST PAY ANY APPLICABLE PLAN DEDUCTIBLES AND COPAYS BEFORE THIS PLAN CAN PAY ANY BENEFITS.

BENEFIT PLAN PAYMENT SUMMARY INFORMATION (11)
$20.30

SATISFIED 2010 TO-DATE	DEDUCTIBLE	OUT OF POCKET
FAMILY / $$ (12)	$1000.00 / $500.00	$1328.77 / $1281.49
PLAN YEAR 2010 (13)	FAMILY $1000.00 / INDIV $500.00	FAMILY $4000.00 / INDIV $4000.00

CLAIM FORM
SIGNED CLAIM FORM IS REQUIRED

1. **PLEASE FULLY COMPLETE THIS FORM PAGE 1 & PAGE 2**
2. **ATTACH HCFA/UB04-MEDICAL BILLS & EOBS FROM ANY OTHER INSURANCE YOU HAVE**
3. **SEND ALL CORRESPONDENCE TO:**

WEB-TPA
P.O. Box 2415
Grapevine, TX 76099-2415

Toll-Free: 866-975-9468
Fax: 469-417-1969
Email: benefit.assist@webtpa.com

IMPORTANT NOTICE:
This plan of insurance is secondary, in most instances, to any health insurance you have. If you have other insurance, submit your claim (health and/or dental) to your other insurer. When you receive their Benefit Statement, send it to us along with your HCFA/UB04 (medical bills) and this completed form. Note: **The accident policy benefits are limited and may not provide 100% coverage.**
coverage.

≺ IF PART 1-A & PART 1-B ARE NOT COMPLETED IN FULL THIS CLAIM CANNOT BE PROCESSED AND WILL BE RETURNED ≻

PART 1-A – TO BE COMPLETED IN FULL BY THE ORGANIZATION/SCHOOL

Organization/School District/College Name Nevada Public Agency Insurance Pool Policy Number 28-3767-20

School/Team/League Name ______ Phone No. ( ) ______

Address ______ Email ______

______ Type of Activity/Sport ______

If Athletics, designate ☐P.E. Class ☐Intramural ☐Interscholastic ☐Intercollegiate ☐Game ☐Jr. Varsity ☐Varsity ☐Youth ☐Adult ☐Practice ☐Other ______

Name of injured person/student ______

Date of Accident ______ Accident Time ______

Date of First Treatment ______ Has treatment been completed? ☐Yes ☐No

Where and how did accident occur? (Please be specific) ______

______

______

______

Part of body Injured ______ ☐Right or ☐Left At the time of the accident, was the claimant involved in a sponsored and supervised activity and were they a current student/member of the Organization/School District? ☐Yes ☐No

Under whose supervision? ______ Was he/she a witness? ☐Yes ☐No

Authorized Signature ______ Title ______ Date ______

(MUST BE SIGNED BY AN ORGANIZATION/SCHOOL OFFICIAL UNLESS INJURY DID NOT OCCUR DURING AN ORGANIZATION/SCHOOL ACTIVITY. SIGNATURE IS REQUIRED)

PART 1-B – TO BE COMPLETED IN FULL BY CLAIMANT – OR BY PARENT/LEGAL GUARDIAN IF CLAIMANT IS A MINOR

Injured Party/Student Legal Name ______ Preferred/Nickname: ______

Date of Birth ______ Age ______ Grade Level ______ ☐Male ☐Female

Claimant is a ☐Student ☐Player ☐Coach ☐Official/Umpire ☐Volunteer ☐Child Care ☐Participant ☐CE Student (# of credits_____)

Address of Injured Person or Parents/Guardian ______

______

Phone No. ( ) ______ Email Address ______

If Injured party is over age 18: Employer Name and Address ______

______

Phone No. ( ) ______ ☐Self Employed ☐Unemployed

Father/Guardian Name ______

Employer Name and Address ______ Phone No. ( ) ______

______ ☐Self Employed ☐Unemployed

PLEASE CONTINUE TO THE NEXT PAGE OF THE FORM WHICH MUST BE COMPLETED IN FULL

Mother/Guardian Name ____

Employer Name and Address ______________________________ Phone No. (   )__________

____ ☐Self Employed ☐Unemployed

If Dental Injury: Please submit verification from the dentist that the tooth/teeth are whole, sound and natural.

Is claimant covered under any other medical and or dental insurance policy? ☐Yes ☐No

Is claimant covered under a government sponsored insurance such as Medicare/Medicaid? ☐Yes ☐No

Name of all companies providing claimant insurance coverage or prepaid health plans

Name of Company	**Address**	**Policy #**

Are benefits due for this claim under these other insurance coverages? ☐Yes ☐No **(See IMPORTANT NOTICE at top of form on page 1)**

Does your son or daughter have medical insurance coverage as an eligible dependent from a previous marriage as mandated in a divorce decree? ☐Yes ☐No If yes, please give name, address and phone number of responsible party ______________________

____

AFFIDAVIT: I verify that the above statement on other insurance is accurate and complete. I understand that the intentional furnishing of incorrect information via the U.S. Mail may be fraudulent and violate federal laws as well as state laws. I agree that it is determined at a later date that there are other insurance benefits collectible on this claim I will reimburse Gerber Life Insurance Company to the extent for which Gerber Life Insurance Company would not have been liable.

Signature: Injured Person, Parent or Guardian ______________________________ Date: __________

SIGNATURE IS REQUIRED

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize any employer, health plan, insurance company, hospital, physician, health care profession, clinic, laboratory, pharmacy, medical facility or other person that has provided treatment, payment, or services in connection with this claim to disclose, when requested to do so, all information with respect to any injury, policy coverage, medical history, consultations, prescription or treatment, and copies of all hospital or medical records and itemized bills to WebTPA, Inc. and Gerber Life Insurance Company, it's agents, employees and representatives.

I hereby authorize WebTPA, Inc. to discuss any information related to medical expenses incurred or treatments rendered in connection with this claim, with Special Markets Insurance Consultants, Inc. representatives and their assigned agents and to officials at the school or organization through which this policy is issued. A photo static copy of this authorization shall be considered as effective and valid as the original.

Signature: Injured Person, Parent or Guardian ______________________________ Date: __________

FRAUD NOTICE STATEMENTS

NOTICE TO APPLICANTS: "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 MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES."

RESIDENTS OF ALASKA APPLICANTS: "A PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE AN INSURANCE COMPANY FILES A CLAIM CONTAINING FALSE, INCOMPLETE OR MISLEADING INFORMATION MAY BE PROSECUTED UNDER STATE LAW."

RESIDENTS OF ARKANSAS APPLICANTS: "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."

RESIDENTS OF ARIZONA APPLICANTS: "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."

RESIDENTS OF COLORADO APPLICANTS: "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."

RESIDENTS OF DISTRICT OF COLUMBIA APPLICANTS: "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."

RESIDENTS OF FLORIDA RESIDENTS APPLICANTS: "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."

RESIDENTS OF KANSAS APPLICANTS: "ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON CAUSES TO BE PRESENTED OR PREPARES WITH KNOWLEDGE OR BELIEF THAT IT WILL BE PRESENTED TO OR BY AN INSURER, PURPORTED INSURER, BROKER OR ANY AGENT THEREOF, ANY WRITTEN STATEMENT AS PART OF, OR IN SUPPORT OF, AN APPLICATION FOR THE ISSUANCE OF, OR THE RATING OF AN INSURANCE POLICY, OR A CLAIM FOR PAYMENT OR OTHER BENEFIT PURSUANT TO AN INSURANCE POLICY WHICH SUCH PERSON KNOWS TO CONTAIN MATERIALLY FALSE INFORMATION CONCERNING ANY FACT MATERIAL THERETO, OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT WHICH IS A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES."

RESIDENTS OF KENTUCKY APPLICANTS: "ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE 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."

RESIDENTS OF LOUISIANA APPLICANTS: "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."

RESIDENTS OF MAINE APPLICANTS: "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."

RESIDENTS OF MARYLAND APPLICANTS: "ANY PERSON WHO KNOWINGLY AND WILLFULLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY AND WILLFULLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON."

RESIDENTS OF MINNESOTA APPLICANTS: "ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE/SHE IS FACILITATING A FRAUD AGAINST ANY INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD."

RESIDENTS OF NEW JERSEY APPLICANTS: "ANY PERSON WHO INCLUDES ANY FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR AN INSURANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES."

RESIDENTS OF NEW MEXICO APPLICANTS: "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 CIVIL FINES AND CRIMINAL PENALTIES."

RESIDENTS OF NEW YORK APPLICANTS: "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."

RESIDENTS OF OHIO APPLICANTS: "ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE/SHE IS FACILITATING A FRAUD AGAINST ANY INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD."

RESIDENTS OF OKLAHOMA APPLICANTS: "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."

RESIDENTS OF OREGON APPLICANTS: "ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD OR SOLICIT ANOTHER TO DEFRAUD AN INSURER: (1) BY SUBMITTING AN APPLICATION, OR (2) BY FILING A CLAIM CONTAINING A FALSE STATEMENT AS TO ANY MATERIAL FACT, MAY BE VIOLATING STATE LAW."

RESIDENTS OF PENNSYLVANIA APPLICANTS: "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."

RESIDENTS OF TENNESSEE APPLICANTS: "IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS."

RESIDENTS OF TEXAS APPLICANTS: IF A LIFE, HEALTH AND ACCIDENT INSURER PROVIDES A CLAIM FORM FOR A PERSON TO USE TO MAKE A CLAIM, THAT FORM MUST CONTAIN THE FOLLOWING STATEMENT OR A SUBSTANTIALLY SIMILAR STATEMENT: "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."

RESIDENTS OF VERMONT APPLICANTS: "ANY PERSON WHO KNOWINGLY PRESENTS A FALSE STATEMENT IN AN APPLICTION FOR INSURANCE MAY BE GUILTY OF A CRIMINAL OFFENSE AND SUBJECT TO PENALTIES UNDER STATE LAW."

RESIDENTS OF VIRGINIA APPLICANTS: "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 AND DENIAL OF INSURANCE BENEFITS."

RESIDENTS OF WASHINGTON APPLICANTS: "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."

RESIDENTS OF WEST VIRGINIA APPLICANTS: "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."