Accident Insurance
Instructions for Filing a Claim

The accident insurance plan is designed to cover all registered participants of the policyholder while they are engaged in policyholder sponsored and supervised activities. The plan will reimburse claimants for eligible expenses that are not payable by the claimant's healthcare plan or any other insurance plan providing reimbursement for medical expenses. Therefore, prior to filing a claim against the accident insurance policy, the claimant must first file the claim with his or her healthcare plan.

Please observe the following claim filing procedures:
Please include the policy number on all correspondence to facilitate the handling of your claim

1. Obtain a claim form from the sponsoring organization. Use only one form for each accident, regardless of the number of expenses incurred for the particular accident.

2. An official representative from the sponsoring organization should complete and sign Section A of the claim form. Section A requests a description of how the accident occurred. Please provide a complete, detailed description. For example, "Basketball" is not an acceptable description; however, "Twisted left ankle while playing basketball" is acceptable.

3. The claimant, or the claimant's parent or guardian if claimant is a minor, should complete and sign Section B of the claim form. Complete all questions. Please do not leave any questions in Section B blank. The company may reject incomplete claim forms. Section B includes the section entitled "AUTHORIZATION and ASSIGNMENT OF BENEFITS".

4. Submit itemized bills that provide the dates of service, the procedure codes, the diagnosis, and the charge(s). "Balance Due" bills are not acceptable because they do not provide all of the information needed to examine a claim.

5. When submitting charges for Physical Therapy, the itemized bill must be accompanied by the prescription and include the frequency and the duration of the treatment.

6. Submit copies of the Explanation of Benefits (EOB) statements from the claimant's healthcare plan. The EOB's reflect his or her healthcare plan payments for services rendered and identify the remaining amount that is the claimant's responsibility. Each itemized bill submitted for reimbursement should have a corresponding EOB.

7. Mail the fully completed claim form, each itemized bill (and the prescription, if applicable) and the corresponding EOB to the following address:

Please include the Policy Number on all correspondence
CHARTIS
Accident & Health Claims Department
PO Box 25987
Shawnee Mission, KS 66225-5987
800-551-0824 / fax: 866-893-8574

NOTE: The Policy is an Accident Insurance Policy. It does not provide reimbursement for illness or for injuries that are not the result of an Accident. It is subject to exclusions and limitations. The policy may also contain a deductible, which may be the claimant's responsibility.

PROOF OF LOSS

CHARTIS Accident & Health Claims Department P.O. Box 25987 Shawnee Mission, KS 66225-5987 800-551-0824 / fax: 866-893-8574	**NAME OF GROUP:** State of Arizona and its Departments, Agencies, Boards, Commissions and Universities **POLICY NUMBER:** SRG9132352

SPECIAL RISK ACCIDENT CLAIM FORM (BSR_EXS)

INSTRUCTIONS:

1.) You must have SECTION A fully completed by a designated official of the Policyholder.
2.) SECTION B is to be completed, signed and dated by the claimant or parent/guardian of claimant, if claimant is a minor.
3.) Attach itemized bills for all medical expenses being claimed including the claimant's name, condition being treated (diagnosis), description of services, date of service(s) and the charge made for each service. PLEASE MAIL COMPLETED FORM AND BILLS TO ABOVE ADDRESS.

EXCESS PLAN - Eligible covered expenses will be determined after benefits have been paid by other valid and collectible insurance. You must submit your claim to your other insurance company first. When you receive their Benefit Statement (EOB) send it to us along with the itemized bills. If you have no other insurance coverage, benefits will be paid on a Primary basis up to the policy maximum. Benefits for eligible expenses will be paid per policy terms.

The furnishing of this form, or its acceptance by the Company, must not be construed as an admission of any liability on the Company, nor a waiver of any of the conditions of the insurance contract.

SECTION A - MUST BE COMPLETED AND SIGNED BY A DESIGNATED REPRESENTATIVE OF THE POLICYHOLDER

NAME/ AND/OR LOCATION OF GROUP/CLUB/SPORT/SCHOOL, ETC.

CLAIMANT'S FULL NAME (PLEASE PRINT CLEARLY OR TYPE)	SOCIAL SECURITY NO. (IF AVAILABLE)	DATE OF BIRTH	NAME OF SUPERVISOR

DATE COVERAGE BEGAN	DATE COVERAGE WILL END/HAS ENDED

NATURE OF INJURY (DESCRIBE FULLY, INCLUDING WHICH PART OF BODY WAS INJURED.)	DESCRIBE HOW, WHEN AND WHERE ACCIDENT OCCURRED (DATE AND TIME).

NAME OF ACTIVITY / INDICATE THE SPORT (IF APPLICABLE)	DID ACCIDENT OCCUR:		
	A. WHILE CLAIMANT WAS SUPERVISED	☐ YES	☐ NO
	B. DURING SPONSORED ACTIVITY	☐ YES	☐ NO
	C. DURING PROGRAMMED HOURS	☐ YES	☐ NO
	D. WHILE TRAVELING TO OR FROM REGULARLY SCHEDULED ACTIVITY IN A SUPERVISED GROUP	☐ YES	☐ NO

DATE LAST WORKED	DATE RETURNED TO WORK	WEEKLY EARNINGS

POLICYHOLDER REPRESENTATIVE (PLEASE PRINT OR TYPE)	TITLE	DAYTIME TELEPHONE NUMBER ( )

SIGNATURE OF POLICYHOLDER REPRESENTATIVE DATE

SECTION B - MUST BE COMPLETED

LIST NAME, ADDRESS, AND PHONE # OF OTHER INSURANCE COMPANIES UNDER WHICH CLAIMANT IS INSURED:	POLICY #/ACCOUNT #

IF CLAIMANT IS A MINOR, NAME OF CLAIMANT'S GUARDIAN/RELATIONSHIP TO CLAIMANT

ADDRESS OF CLAIMANT (IF CLAIMANT IS A MINOR, NAME AND ADDRESS OF CLAIMANT'S GUARDIAN)	GUARDIAN'S SOCIAL SECURITY NUMBER
NAME/ADDRESS/TELEPHONE # OF EMPLOYER (IF CLAIMANT IS A MINOR, GUARDIAN'S EMPLOYER)	EMPLOYER'S DAYTIME TELEPHONE # ( )

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

AUTHORIZATION and ASSIGNMENT OF BENEFITS

I, the undersigned authorize any hospital or other medical-care institution, physician or other medical professional, pharmacy, insurance support organization, governmental agency, group policyholder, insurance company, association, employer or benefit plan administrator to furnish to the Insurance Company named above or its representatives, any and all information with respect to any injury or sickness suffered by, the medical history of, or any consultation, prescription or treatment provided to, the person whose death, injury, sickness or loss is the basis of claim and copies of all of that person's hospital or medical records, including information relating to mental illness and use of drugs and alcohol, to determine eligibility for benefit payments under the Policy Number identified above. I authorize the group policyholder, employer or benefit plan administrator to provide the Insurance Company named above with financial and employment-related information. I understand that this authorization is valid for the term of coverage of the Policy identified above and that a copy of this authorization shall be considered as valid as the original. I understand that I or my authorized representative may request a copy of this authorization.

I authorize payment of medical benefits to the physician or supplier for service performed. ☐ YES ☐ NO

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.

For residents of New York: 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, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the subject motor vehicle or stated claim for each such violation.

For residents of Pennsylvania: 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 and subjects such person to criminal and civil penalties.

For claimants not residing in California, New York, or Pennsylvania: 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.

CLAIMANT OR AUTHORIZED PERSON'S SIGNATURE DATE