NATIONAL UNION FIRE INSURANCE COMPANY
MAIL CLAIM FORM TO:
AIG, EDUCATIONAL MARKETS
MAIL CENTER
P.O. BOX 26008
OVERLAND PARK, KS 66225
(800) 257-6250
www.studentinsurance.com

NOTIFICATION OF INJURY

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowlingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Reference Number

FOR OFFICE USE

Policy Number

Coverage Code

FORM MUST BE COMPLETED IN FULL & MAILED TO OUR OFFICE WITHIN 90 DAYS FROM THE DATE OF THE ACCIDENT

PART I – ACCIDENT REPORT

1A. Name of Organization	1B. Name of Team

2A. Name of Claimant (Last) (First) (Middle Initial)	2B. Social Security No.	2C. Birthdate	2D. Sex

3. Nature of Injury (Please describe fully indicating what part of body was injured – e.g. broken arm, sprained ankle, etc.)

4. Describe how accident occurred. (Please provide all details.) **MUST BE A BODILY INJURY DUE TO AN ACCIDENT.**

5A. Did Accident Occur:	Yes	No
a) while the claimant was supervised?	❑	❑
b) during sponsored activity?	❑	❑
c) during programmed hours?	❑	❑
d) on activity premises?	❑	❑
e) while traveling directly and uninterruptedly to or from a regularly scheduled activity in a supervised group?	❑	❑

5B. a) Date of Accident

b) Time

c) Place

5C. Name of Activity

5D. (Check One)
❑ Member/Player ❑ Coach ❑ Manager ❑ Other

5E. Name and Title of Supervisor

6A. _____
Signature of Coach, Manager or Delegated Authority

6B. _____
Title

6C. _____
Date

PART II – TO BE COMPLETED BY PARENT/GUARDIAN OR CLAIMANT (IF ADULT)

1A. Name of Father/Guardian or Claimant (if adult) ❑ None	1B. Social Security No.	1C. Address/City/State/Zip	1D. Phone Number
2A. Name of Mother/Guardian or Spouse (if adult) ❑ None	2B. Social Security No.	2C. Address/City/State/Zip	2D. Phone Number

3A. Name of Father/Guardian's or Claimant's (if adult) Employer ❑ None	3B. Address/City/State/Zip of Employer	3C. Phone Number
4A. Name of Mother/Guardian's or Spouse's (if adult) Employer ❑ None	4B. Address/City/State/Zip of Employer	4C. Phone Number

5A. List all Insurance Company(ies) under which the claimant is insured ❑ None	5B. Policy Number(s)	5C.
_____	_____	❑ Medicaid ❑ Individual ❑ Group ❑ Govt.
_____	_____	❑ Medicaid ❑ Individual ❑ Group ❑ Govt.
_____	_____	❑ Medicaid ❑ Individual ❑ Group ❑ Govt.
_____	_____	❑ Medicaid ❑ Individual ❑ Group ❑ Govt.
_____	_____	❑ Medicaid ❑ Individual ❑ Group ❑ Govt.

Affidavit: I verify that the above information regarding 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.

_____ _____
Signature of Parent/Guardian or Claimant (if adult) Date

Authorization: I hereby authorize any physician or hospital who has treated or attended to the above claimant to furnish the insurance company or its representative any information requested. A photocopy of this authorization is to be considered valid.

_____ _____
Signature of Insured (Parent or Guardian if claimant is under 18) Date

First Health Network

SEE CLAIM INSTRUCTIONS ON THE BACK OF THIS FORM

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CLAIM INSTRUCTIONS

Treatment must commence within 90 days from the date of the accident.

1. In case of an accident, notify the school/organization immediately.

2. Notify **ALL** treatment facilities (physician's office, hospital, etc.) of this insurance coverage so that any invoices and/or Explanation of Benefits (EOB) can be sent directly from the medical facility to Chartis.

3. Have Part I and Part II completed on the Notification of Injury form. Do not leave any blank spaces or write "N/A" in any space. If either parent or guardian is uninvolved, deceased, unemployed, self-employed or disabled, please state so. If you are employed, but do not have insurance, please state "NO INSURANCE" and provide us with a statement from your employer that the claimant has no insurance. Otherwise, our office will submit an insurance questionnaire to your employer to be used as verification of no dependent coverage.

4. Attach any itemized bills to the claim form, along with any corresponding Explanation of Benefits (EOB) for each itemized bill. An itemized bill includes treatment rendered, the dates of the treatment, diagnosis codes, physician's or hospital's name, address and tax i.d. number. Balance Due bills are not acceptable. Be sure to attach any receipts for bills paid out-of-pocket. Otherwise, benefits will be paid to the provider of service. Please Note: Both an itemized bill and EOB (if applicable) must be submitted for claims to be considered for accident medical expense benefits.

5. Mail the Notification of Injury form, along with any other applicable correspondence to our office within 90 days from the date of the accident. Do not leave this form with the school, coach, hospital, physician, etc. Our address is **AIG, Educational Markets Mail Center – K-12, P.O. Box 26008, Overland Park, KS 66225**. If you need further assistance, feel free to contact Customer Service at **1-800-257-6250 (phone) / 1-856-486-4376 (fax)**. We will be happy to assist you.

If your medical coverage is under an HMO, PPO or similar plan, you must follow their requirements for obtaining benefits. Otherwise, our benefits may be reduced, where applicable, as stated in the policy provisions. This restriction does not apply in every state.