

NOTE: PLEASE READ THIS BEFORE 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
- Please Note: The Accident Insurance Plan Has Exclusions and Benefit Limitations.
The Insurance Plan May Not Pay 100% For All Expenses

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 must be completed in full.
2. In the event the claimant sustained a dental injury, Part C must be completed in full 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.*

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	MOTHER or GUARDIAN
Full Name _____ S.S.# _____	Full Name _____ S.S.# _____
Address _____ <small>(street)</small>	Address _____ <small>(street)</small>
Occupation _____ Employer _____ <small>(city) (state) (zip)</small>	Occupation _____ Employer _____ <small>(city) (state) (zip)</small>
Employer Address _____ <small>(street)</small>	Employer Address _____ <small>(street)</small>
Name & Address of Other Insurance Company _____ <small>(city) (state) (zip)</small>	Name & Address of Other Insurance Company _____ <small>(city) (state) (zip)</small>
Policy/Group No. _____ <input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> HMO/PPO	Policy/Group No. _____ <input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> 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.

- 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.
- 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.
- 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.
- 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.
- I certify that I have read and understand the above information.

(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 _____