**Accident Insurance**
**Instructions for Filing a Claim**

The accident insurance plan is designed to cover all registered participants of the policyholder while they're engaged in policyholder sponsored and supervised activities. The plan will reimburse claimants for eligible expenses which are not payable by your healthcare plan or any other insurance plan providing reimbursement for medical expenses. Therefore, prior to filing a claim against the accident insurance policy, you must first file the claim with your own 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. Only one form is needed for each accident, regardless of the number of expenses incurred for the particular accident.

2. Part I of the claim form should be completed and signed by an official from the sponsoring organization. Part I requests a description of how the accident occurred. Please check to see that a complete description is provided. For example, "Basketball" is not acceptable; however, "Twisted left ankle while playing basketball" is acceptable.

3. Part II of the claim form should be completed and signed by the claimant or the claimant's parent or guardian if claimant is a minor. All questions in Part II must be completed in order for the company to examine your claim. Please do not leave any questions blank. Part II includes the section entitled "Authorization to Release Information."

4. Itemized Bills must be submitted. Itemized Bills 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 properly 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 your own healthcare plan. The EOB's will show how much your healthcare plan paid for the services rendered and the amount which is your responsibility. There should be an EOB for each Itemized Bill you have submitted for reimbursement.

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)**

AGIA, Inc.
P.O. Box 9851
Phoenix, AZ 85068-9851

**Please remember, 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.**

# *Accident Claim Form*

**MAIL TO:** AGIA
P.O. Box 9756
Phoenix, AZ 85068

**QUESTIONS? CONTACT:** 1-800-399-2560

Fairmont Specialty
United States Fire Insurance Company

**Beech Street Preferred Provider Network Plan**

**CAUTION:** Any person who, knowingly and with intent to defraud, or helps commit a fraud against, any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits or may be committing a fraudulent insurance act, which is a crime and subjects such person to criminal and/or civil penalties. ***Residents of the following states, please see reverse side: AZ, CA, CO, HI, OK, PA, TX***

## INSTRUCTIONS

The policy is Full Excess unless otherwise noted in the policy. 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 Benefits Statement (EOB) send it to us along with the itemized bills.

- **Part I** - Must be completed by Policyholder.
- **Part II** - Must be completed by claimant or by the parent or guardian, if the claimant is a minor.
- Send copies of itemized bills showing provider's name, address, tax ID number, diagnosis and procedure codes.
- Attach Explanation of Benefits, additional bills with record of payment or denial from primary insurance carrier.
- All benefits will be payable to the physicians and providers, unless accompanied by paid receipts.
- If employed, but have no other insurance, forward employer(s) letter on employer(s) letterhead to that effect.

Claimants eligible for Medicaid benefits must first file for benefits under this policy before submitting expenses to Medicaid.

## PART I - POLICYHOLDER REPORT

| | | | |
|---|---|---|---|
| Name of Policyholder | | Policy Number | |
| Policyholder Street Address | City | State | Zip Code |
| Policyholder Contact | Telephone No. ( ) | Fax No. ( ) | E-Mail |
| Name of Claimant *(Last Name)* *(First Name)* | | | Social Security No. |
| Date of Birth / / | Sex ☐ Male ☐ Female | Grade *(if applicable)* | Check One *(if applicable)* ☐ Day School ☐ Boarding School |

Nature of Injury *(Describe, fully indicate what part of body was injured - e.g. broken arm, sprained ankle)*

Describe how the Accident occurred, provide all details. Attach a separate sheet, if necessary. **MUST BE A BODILY INJURY DUE TO ACCIDENT.**

Did Accident occur:

While claimant was policyholder supervised? ☐ Yes ☐ No Date of Accident: ____/____/ _____ Time of Accident: _____

During a policyholder sponsored activity? ☐ Yes ☐ No Place of Accident: _____

During scheduled policyholder hours? ☐ Yes ☐ No First Treatment Date: ____/____/ _____

While traveling to or from a policyholder sponsored and supervised activity? ☐ Yes ☐ No

Off Policyholder premises, at home, during the weekend, holiday or summer vacation? ☐ Yes ☐ No

Name and title of person supervising activity? _____ Was he or she a witness? ☐ Yes ☐ No

List other Policyholder insurance. Attach separate sheet, if necessary. Policy Number(s)

**Signature of Authorized Policyholder Representative** **Title** **Date**

## PART II - TO BE COMPLETED BY CLAIMANT OR PARENT / GUARDIAN, IF CLAIMANT IS A MINOR

| | | | | |
|---|---|---|---|---|
| Name of Father or Guardian | Social Security No. | E-Mail Address | | |
| Name of Mother or Guardian | Social Security No. | E-Mail Address | | |
| Street Address of Parents or Guardian | City | State | Zip Code | Telephone No. ( ) |
| Father or Guardian's Insurance Company | Mother or Guardian's Insurance Company | | | |
| Name & Address of Father and Mother's or Guardian's Employer | Address | City | State | Zip Code |

(Over)

## PART II - TO BE COMPLETED BY CLAIMANT OR PARENT / GUARDIAN, IF CLAIMANT IS A MINOR *(Continued)*

List all other insurance policies under which claimant is insured — Policy Number

Is the claimant enrolled in, a member of, or a participant of any of the following as an individual, employee or dependent? If so, please provide a copy of insurance card *(front and back)*.

Preferred Provider Organization (PPO) or similar prepaid health plan? ☐ Yes ☐ No

If Yes, name of PPO or Organization _____

Health Maintenance Organization (HMO) or similar prepaid health plan? ☐ Yes ☐ No

If Yes, name of HMO or Organization _____

If claimant has health care coverage as a dependent from a previous marriage as mandated in a divorce decree, please provide the following:

Name of Policyholder — Name of Insurance Company — Policy Number

**AFFIDAVIT:** I verify that the 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 if it is determined at a later date that there are other insurance benefits collectible on this claim I will reimburse the Company to the extent for which the Company would not have been liable.

**AUTHORIZATION TO RELEASE INFORMATION:** I authorize any Health Care Provider, Doctor, Medical Professional, Medical Facility, Insurance Company, Person or Organization to release any information regarding medical, dental, mental, alcohol or drug abuse history, treatment or benefits payable, including disability or employment related information concerning the patient, to any Fairmont company, the Plan Administrator or their employees and authorized agents for the purpose of validation and determining benefits payable. This data may be extracted for the use in audit or statistical purposes. I understand that I or my authorized representative will receive a copy of this authorization upon request. This authorization or a photostatic copy of the original shall be valid for the duration of this claim.

**PAYMENT AUTHORIZATION:** I authorize all current and future medical benefits, for services rendered and billed as a result of this claim, to be made payable to the physicians and providers indicated on the invoices.

Signature *(Parent or Guardian, if the claimant is a minor)* — Date

## IMPORTANT CLAIM NOTICE

***Notice to Arizona Claimants:*** *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.*

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

***Notice to Colorado Claimants:*** *It is unlawful to knowingly provide false, incomplete, or misleading 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 policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement or aware payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.*

***Notice to Hawaii Claimants:*** *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.*

***Notice to Oklahoma Claimants:*** *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.*

***Notice to Pennsylvania Claimants:*** *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.*

***Notice to Texas Claimants:*** *Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.*