PROOF OF CLAIM

This form should be completed and submitted to the Company within 90 days from date of injury.

Mail completed form to:
STUDENT ASSURANCE SERVICES, INC.
P.O. BOX 196
STILLWATER, MINNESOTA 55082

***NOTICE:** Anyone who knowingly misrepresents or falsifies essential information requested by this form may upon conviction be subject to fine or imprisonment.*

CLAIM PROCEDURE:

1. A school official must complete PART A*.
2. The Insured's parents or guardian must complete PART B.
3. If dental charges — have statement completed on back.
4. See reverse side for important claim procedures.

TO BE COMPLETED BY A SCHOOL OFFICIAL

PART A: NOTICE OF INJURY

1. Name of School ____________________ School District Name ____________________
   School Address ____
   (City) (State) (Zip)
2. Name of Insured ____________________ Social Security # ___ - __ - ____
3. Age ________ Grade ________ Date of Injury ____________ ☐AM ☐PM
4. Under whose supervision? ____________________ Was he/she a witness? ____________
5. The accident was incurred while the Insured was participating in:

INTERSCHOLASTIC SPORTS

( ) Practice
( ) Game
( ) Travel

What sport? ____________________

NON-INTERSCHOLASTIC SPORTS

( ) Travel to/from school
( ) In classroom
( ) Physical Education
( ) On school grounds
( ) Non-school activity
( ) Other – Activity? ____________________

6. Part of the body injured ____________________ ☐R ☐L
7. Describe in detail how and where the injury occurred ____________________

____

Reported by ____
(Signature of School Official) (Title) (Date)

TO BE COMPLETED BY A PARENT OR GUARDIAN

PART B: PARENT STATEMENT

The school is participating in a low cost insurance program that provides benefits for medical expenses not covered by other family insurance. In order for us to determine benefits, you must file a claim with your own insurance carrier and send us a copy of the Explanation of Benefits or rejection letter. The school insurance policy will pay eligible expenses not paid by your own coverage. In order to continue this plan in your school, YOUR COOPERATION is necessary. Your claim will receive prompt attention provided all questions in PART B are answered fully.

1. Parents Name ____________________ Relationship to Insured ____________
   Address ____
   (Street or Route) (City) (State) (Zip)
2. Home phone number ____________________
3. Father's Occupation ____________________ Employer ____________________
   Mother's Occupation ____________________ Employer ____________________
4. List your family or group coverage, please.
   Name of Insurance Company ____________________ ☐Group ☐Individual ☐PolicyNo. ____________
   Address ____
   (Street) (City) (State) (Zip)

I hereby authorize any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance company, or other organization, institution, or person that has any records or knowledge of the claimant's physical or mental health, to give the information to STUDENT ASSURANCE SERVICES, INC. To facilitate rapid submission of such information, I authorize all said sources, to give such records or knowledge to any agency employed by the insurance company to collect and transmit such information. A photocopy of this authorization shall be as valid as the original. This authorization expires one year from the date signed.

__________ (Date) ____________________ (Print Name of Student/Patient) ____________________ (Signature of Parent or Guardian)

FOR COMPANY USE ONLY

	Form	Date
Policy Form ____________	____________	____________
Date Purchased ____________	____________	

TO: Parent or Guardian

STEPS TO FOLLOW WHEN FILING A CLAIM:

1. A school official **must** complete Part A for all school related accidents. The parent or guardian must complete **all** questions in Part B – Parent Statement. If the accident is not school related, parent or guardian **may** complete Part A. **Do NOT leave this Claim Form with the physician or hospital. Complete and submit directly to the Claim's Office at the address indicated below.**

2. Send copies of **itemized bills**. These are the original billings you receive, not monthly statements. **All bills must contain the Provider's Tax ID Number.**

3. Submit copies of all bills to your family and/or group insurance, even if you have a large deductible. This plan is supplemental to all other valid coverage. You must file a claim with your other insurance first. This plan does not cover penalties imposed for failure to use providers preferred or designated by your primary coverage. After you have received payment or copies of "Explanation of Benefits" (EOB) from your family insurance company or insurance administrator (Blue Cross, Group Health, Prudential Insurance, etc.), **send our claim form, copies of itemized bills and your other insurance E.O.B.'s to:**

STUDENT ASSURANCE SERVICES, INC.
P.O. BOX 196
STILLWATER, MN 55082-0196

NO CLAIM CAN BE PROCESSED UNTIL ALL OF THE ABOVE DOCUMENTS ARE PROVIDED.

PLEASE REFER TO THE MASTER POLICY ISSUED TO THE SCHOOL/SCHOOL DISTRICT FOR SPECIFIC DETAILS.

ATTENDING DENTIST'S STATEMENT

(1) DATE OF ACCIDENT	(3) WERE THE TEETH SOUND OR NATURAL PRIOR TO THE CURRENT TREATMENT? ☐ YES ☐ NO
(2) IF PROTHESIS, IS THIS INITIAL PLACEMENT? ☐ YES ☐ NO	(4) ARE ANY SERVICES COVERED BY ANOTHER PLAN? IF SO, NAME PLAN ☐ YES ☐ NO

IDENTIFY ALL TEETH WITH AN "X" THAT WERE INVOLVED IN THIS ACCIDENT

TOOTH NO.	DESCRIPTION OF SERVICE	DATE OF SERVICE	FEE
		TOTAL FEE	

X

DENTIST'S NAME | SIGNATURE | DEGREE

STREET ADDRESS | DATE

CITY | STATE | ZIP | ( ) TELEPHONE

Federal ID Number — No benefits can be paid until we have your ID number.