HINZ CLAIM MANAGEMENT, INC.™

2009-2010 CLAIM FORM

Please follow the time frames listed below and submit to Hinz Claim Management, Inc.

1) **Claim form should be submitted no later than 90 days after the date of injury.**
2) **Itemized bills must be submitted no later than 90 days after the date of treatment.**
3) **Explanation of Benefits (EOB) must be submitted no later than 180 days after the date of treatment.**

PLEASE RETAIN A COPY FOR YOUR FILES

CLAIM PROCEDURE:

1. The school official completes Part A (if school-related injury)
2. The Insured's parent or guardian completes Part B and Part A if a 24/7 injury (with the exception of the signature of the school official)
3. In case of dental charges, the attending dentist must complete statement on the reverse side of this form

PART A: NOTICE OF INJURY FROM SCHOOL

1. Name of School ___________________________________ School District Name ____

   School Address ___________________________________ ____________________ (City) ________________ (State) _______________ (Zip)

2. Contact Name ____________________________________ Phone Number _____________________________

3. Name of Student ___________________________________

4. Date of Injury _____________Time ___:___AM ___:___PM Under whose supervision? _______________________ Was he/she a witness? _____

5. The injury was incurred while the Insured was participating in: (*please check*)

INTERSCHOLASTIC SPORTS
( ) Practice
( ) Game
( ) 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 ____ ( ) Right ( ) Left

7. Describe in detail how and where the injury occurred____
____

Reported by ____ Signature of School Official ____________________________________ Title ___________________ Date

PART B: STATEMENT FROM PARENT OR GUARDIAN *(Important Information on Reverse Side)*

1. Parent's Name ______________________________________ Relationship to Student ____

   Address ____ (_______)_________________________ Home Phone Number

   ___________________ City ___________ State ____________ Zip

2. Father's Occupation ________________________________ Employer ________________________ ________________________ Phone

3. Mother's Occupation ________________________________ Employer ________________________ ________________________ Phone

4. Student's Date of Birth ______________ M / F Grade ______ Student's Social Security #: ___ ___ ___-- ___ ___ -- ___ ___ ___ ___

5. **<u>This area must be completed</u>**, with signature of guardian or parent. List all other insurance coverages in force. Add other pages as necessary.

   Name of Insurance Company _____________________________________ ___Group ____ Individual Policy #_________________________

   Phone Number (________)_____________________________________ Whose insurance is it? ( ) Mother ( ) Father ( ) Guardian

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 HINZ CLAIM MANAGEMENT, 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 ________________________________ Signature of Parent or Guardian

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

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STEPS TO FOLLOW WHEN FILING A CLAIM:

- **Complete and submit the Claim Form to Hinz Claim Management, Inc. no later than 90 days after the date of injury.**
- **DO NOT leave this Claim Form with the physician or hospital.**
- Review the 2009-2010 Student Accident Coverage brochure for a summary of benefits, limitations, and exclusions. Please contact your child's school for a copy of the brochure, if you have not received one.
- A school official must complete Part A for all school-related injuries. The parent or guardian must complete all questions in Part B – Statement from Parent or Guardian. If the injury is not school-related and the 24/7 coverage has been purchased, the parent or guardian must complete Part A with the exception of the signature of the school official.
- Students must be treated by a licensed medical or dental provider **no later than 30 days** after the date of the covered injury**. Treatment must be completed no later than 52 weeks from the date of the covered injury.**
- **Itemized bills must be submitted to Hinz Claim Management, Inc. no later than 90 days after the date of treatment.** All bills must include the diagnosis and procedure codes.
- Please remember that this plan is **EXCESS** to all other valid coverages. You **MUST** file a claim with your primary insurance carrier or other plan carrier first, even if you have a large deductible.
- When you receive your Explanation of Benefits (EOB) from your primary insurance carrier, other plan carrier or claims administrator send them to Hinz Claim Management no later than 180 days after the date of treatment.
- All documents should be sent to the following address within the **required time frames**: Student Accident Coverage, Hinz Claim Management, Inc. 525 W. Monroe Street, Suite 2400, Chicago, IL 60661.
- For additional questions, please call (800) 419-3206.

ATTENDING DENTIST'S STATEMENT

1. Date of Injury_________________
2. If Prosthesis, is this initial placement?___________
3. Were the teeth sound or natural prior to the current treatment? ______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 INJURY	TOOTH NO.	DESCRIPTION OF SERVICE	DATE OF SERVICE	FEE
			TOTAL FEE	

Print Dentist's Name ______________________ Signature ______________________

Street Address ______________________ Date ______________________

City State Zip ______________________ Telephone ______________________

Federal tax ID Number