SEE REVERSE SIDE FOR CLAIM FILING INSTRUCTIONS

1. Report school related injuries to the school within 72 hours
2. Complete this form
3. Attach all bills
4. Mail to

myers • stevens & toohey & co., inc.
26101 marguerite parkway
mission viejo, california 92692-3203
(949) 348-0656 • fax (949) 348-2630

STUDENT INSURANCE CLAIM FORM

Beech Street Corporation

PART A CLAIMANT INFORMATION

NAME OF INSURED PERSON FIRST MI LAST | STUDENT SOCIAL SECURITY # — — ◀OR▶ | STUDENT I.D. # FROM I.D. CARD

NAME OF SCHOOL | NAME OF SCHOOL DISTRICT | AGE | GRADE | ☐ FEMALE ☐ MALE | DATE OF BIRTH MO / DAY / YR

ADDRESS OF SCHOOL | CITY | STATE | ZIP CODE

DATE OF INJURY/SICKNESS MO / DAY / YR | **TIME OF INJURY** : ☐☐ (CIRCLE ONE) | INJURY OCCURRED: PLEASE ✔ ONE ☐ Interscholastic Practice ☐ Interscholastic Game ☐ P.E. ☐ Classroom ☐ Travel ☐ At Home ☐ Intercollegiate Sport ☐ Field Trip ☐ Other_____ | TYPE OF SPORT

DETAILS OF SICKNESS OR HOW THE INJURY OCCURRED. **PLEASE BE SPECIFIC** (NOTE: IF YOUR SCHOOL USES AN ACCIDENT REPORT FORM, PLEASE ATTACH A COPY OF THE REPORT ALSO).

WAS STUDENT PARTICIPATING IN SPORT NOT SCHOOL-RELATED? (IF YES, LIST NAME AND PHONE NO. OF GROUP)
☐ YES
☐ NO

WHAT **PART** OF THE BODY WAS INJURED?

HAS THE STUDENT SUFFERED FROM SAME OR SIMILAR CONDITION BEFORE?
☐ YES ☐ NO IF YES, WHEN?

NAME, ADDRESS AND PHONE NO. OF INSURED'S FAMILY PHYSICIAN | CITY | STATE | ZIP CODE | TELEPHONE NO. ( )

COMPLETE THE FOLLOWING ONLY IF INJURY IS SCHOOL RELATED

NAME OF SCHOOL SUPERVISOR | DATE SCHOOL WAS NOTIFIED OF ACCIDENT | WAS HE/SHE A WITNESS TO THE ACCIDENT? ☐ YES ☐ NO

NAME OF SCHOOL OFFICIAL | SIGNATURE OF SCHOOL OFFICIAL **(REQUIRED ONLY IF SCHOOL RELATED)** X | DATE SIGNED | SCHOOL TELEPHONE NO. ( )

PART B CLAIMANT, PARENT OR GUARDIAN STATEMENT *(PLEASE PRINT OR TYPE CLEARLY)*

RELATIONSHIP TO INJURED
☐ SELF ☐ FATHER ☐ MOTHER ☐ LEGAL GUARDIAN ☐ OTHER

IS THIS DEPENDENT COVERED BY OTHER HEALTH AND/OR ACCIDENT INSURANCE PLAN?
☐ YES ☐ NO

NAME OF CLAIMANT (IF ADULT), OR LEGAL MALE GUARDIAN | S.S. # OF LEGAL MALE GUARDIAN | HOME TELEPHONE NO. ( )

ADDRESS | CITY | STATE | ZIP CODE

NAME OF EMPLOYER | WORK TELEPHONE AND EXTENSION NO. ( )

ADDRESS OF EMPLOYER | CITY | STATE | ZIP CODE

NAME OF OTHER HEALTH AND/OR ACCIDENT INSURANCE COMPANY THROUGH LEGAL MALE GUARDIAN | POLICY NUMBER | TELEPHONE NO. ( )

MAILING ADDRESS OF INSURANCE COMPANY | CITY | STATE | ZIP CODE

NAME OF LEGAL FEMALE GUARDIAN | S.S. # OF LEGAL FEMALE GUARDIAN | HOME TELEPHONE NO. ( )

ADDRESS | CITY | STATE | ZIP CODE

NAME OF EMPLOYER | WORK TELEPHONE AND EXTENSION NO. ( )

ADDRESS OF EMPLOYER | CITY | STATE | ZIP CODE

NAME OF OTHER HEALTH AND/OR ACCIDENT INSURANCE COMPANY THROUGH LEGAL FEMALE GUARDIAN | POLICY NUMBER | TELEPHONE NO. ( )

MAILING ADDRESS OF INSURANCE COMPANY | CITY | STATE | ZIP CODE

I understand that 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 facts material thereto commits a fraudulent act, which is a crime, and may subject such person to fines and/or imprisonment.
I hereby authorize any school authority, trust fund, employer, insurance company or person who has attended or examined the claimant to disclose to Myers-Stevens & Toohey & Co., Inc., when requested to do so, any information regarding any injury, illness, policy coverage, medical history, consultation, prescription or treatment, and copies of all hospital or medical records and itemized bills, and to pay benefits based upon this information. A photostatic copy of this authorization shall be considered as valid and effective as the original.

CLAIMANT, PARENT OR LEGAL GUARDIAN SIGNATURE
X

RELATIONSHIP TO CLAIMANT | DATE

AUTHORIZATION TO PAY BENEFITS TO PROVIDER. I authorize payment of Medical payments to Physician or Supplier for Services on the attached.

SIGNATURE OF PARENT OR LEGAL GUARDIAN_____ DATE_____

CLAIM FILING PROCEDURE

❶ Report school related injuries to the school within 72 hours.

❷ Have school complete PART A. (Parents may fill out PART A if injury is not school related.)

❸ Claimant, parent or guardian complete PART B.

❹ **IMPORTANT: Both parts must be completed <u>in full</u> or claim will not be processed.**

❺ Mail form to our office with all itemized bills **within 90 days of the first date of treatment.**

❻ At the same time, please file a claim with your other family health and/or accident carrier. This can include employee plans, union plans, CHAMPUS (military plans), service contracts, self-insured benefit plan, or health maintenance organizations (HMO's).

❼ When you receive a notice of payment, a notice of denial, or a letter stating you have met your deductible from your other health and/or accident carrier, please forward this information to our office.

❽ If you have any questions, please call our office at 949-348-0656.

NON-DUPLICATION OF BENEFITS: *(Not applicable in Oregon)* In order to keep premiums as affordable as possible, these plans pay benefits on a non-duplicating basis. This means, if a person is covered by one or more of our plans and by any other valid insurance or health agreement, any amount payable or provided by the other coverages will be subtracted from the covered expenses and we will pay benefits based on the remaining amount.

COMMONLY ASKED QUESTIONS

❶ **Do I have to go to a specific doctor or hospital?**

*No, you can go to the doctor or hospital of your choice. *<u>However, if you go to a doctor or hospital that is part of the</u>* ***Beech Street*** *<u>preferred provider network, you may have your out-of-pocket expenses significantly reduced.</u> To find a participating doctor or hospital in your area, call 800-877-1666, 24-hours a day, 7-days a week or log on to <u>www.beechstreet.com</u>.*

** Does not apply to Family Health Care Coverage or where prohibited by law.*

❷ **Do I need to attach a claim form for each bill?**

No, only one claim form is required per injury or sickness.

In the states of: AK, CO, ID, NM, OR, WA, UT
Underwritten by:

ACE

myers•stevens

myers • stevens & toohey & co., inc.
26101 marguerite parkway
mission viejo, california 92692-3203
(949) 348-0656
fax (949) 348-2630

In the states of: AZ, CA, IA, IN, KS, MO, NE and NV
Underwritten by:

BCS®

For residents of California and Texas: 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.

For residents of Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or 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 policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.