AIG
Accident/Health Claims Department
P.O. Box 25987
Shawnee Mission, KS 66225-5987
800-551-0824 / fax: 866-893-8574

PROOF OF LOSS

Name of Group **Perris Union High School District**

Policy Number: **SRG 0009140136**

PLAY IT SAFE CONCUSSION CARE℠ PROGRAM
BLANKET ACCIDENT CLAIM FILING INSTRUCTIONS

How to File with the Play It Safe Blanket Accident Policy:

When an injury occurs, a claim must be filed with the Play It SafeSM claims administrator for the Blanket Accident policy. In order for charges to be paid under the Blanket Accident policy by the administrator, the following steps must be followed:

1. The Accident Claim form must be fully completed and signed by claimant and appropriate school/team representative. Each new injury requires a new form. This should be sent immediately to the claims administrator listed below.

2. File with the Primary Insurance first! If the student/athlete has any other insurance coverage, it must pay its normal benefit before the Play It SafeSM Blanket Accident policy will pay anything.

3. After any other insurance coverage has paid its normal benefit, In order for balance to be considered under the Blanket Accident policy by the claims administrator, the following items must be submitted to the Claim Administrator listed below:

   a. Itemized bills for services rendered by provider must be submitted. Ask the provider for "the form used to bill insurance". (aka "1500" or "UB") (Statements on Account or balance due bills are not acceptable for payment.)

   b. Copies of final determinations made by the student's primary insurance (Explanation of Benefits - EOBs) must be submitted, including any denials made by the primary insurance carrier. The EOBs must include any denial message (not just denial code).

   c. For prescriptions, the detailed prescription slip provided by the pharmacy must be provided. This form includes the name, code and dosage of the medication and the names of the patient and prescribing physician. (A register receipt is not acceptable for payment)

   d. For physical therapy claims, the physician's prescription must be provided.

All claims should be mailed to the claims administrator listed below:

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Caution: Any person who, knowingly and with intent to defraud, or helps to 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 civil penalties.

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SPECIAL RISK ACCIDENT CLAIM FORM (BSR_EXS)

INSTRUCTIONS:
1.) You must have SECTION A fully completed by a designated official of the Policyholder.
2.) SECTION B is to be completed, signed and dated by the claimant or parent/guardian of claimant, if claimant is a minor.
3.) Attach itemized bills for all medical expenses being claimed including the claimant's name, condition being treated (diagnosis), description of services, date of service(s) and the charge made for each service. PLEASE MAIL COMPLETED FORM AND BILLS TO ABOVE ADDRESS.

EXCESS PLAN - 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 Benefit Statement (EOB) send it to us along with the itemized bills. If you have no other insurance coverage, benefits will be paid on a Primary basis up to the policy maximum. Benefits for eligible expenses will be paid per policy terms.

The furnishing of this form, or its acceptance by the Company, must not be construed as an admission of any liability on the Company, nor a waiver of any of the conditions of the insurance contract.

SECTION A - MUST BE COMPLETED AND SIGNED BY A DESIGNATED REPRESENTATIVE OF THE POLICYHOLDER

NAME/ AND/OR LOCATION OF GROUP/CLUB/SPORT/SCHOOL, ETC.

Perris Union High School District, 155 East Fourth St, Perris, CA, 92584

CLAIMANT'S FULL NAME (PLEASE PRINT CLEARLY OR TYPE)	SOCIAL SECURITY NO. (IF AVAILABLE)	DATE OF BIRTH	NAME OF SUPERVISOR
			n/a

DATE COVERAGE BEGAN (DATE OF INJURY)	DATE COVERAGE WILL END/HAS ENDED
	n/a

NATURE OF INJURY (DESCRIBE FULLY, INCLUDING WHICH PART OF BODY WAS INJURED)	DESCRIBE HOW/WHEN/WHERE ACCIDENT OCCURRED (DATE AND TIME)

NAME OF ACTIVITY

INDICATE THE SPORT (IF APPLICABLE)

DID ACCIDENT OCCUR:

A. WHILE CLAIMAINT WAS SUPERVISED ☐ Yes ☐ No

B. DURING SPONSORED ACTIVITY ☐ Yes ☐ No

C. DURING PROGRAMMED HOURS ☐ Yes ☐ No

D. WHILE TRAVELING TO OR FROM REGULARLY SCHEDULED ACTIVITY IN A SUPERVISED GROUP ☐ Yes ☐ No

DATE LAST WORKED	DATE RETURNED TO WORK	WEEKLY EARNINGS
n/a	n/a	n/a

POLICYHOLDER REPRESENTATIVE (PLEASE PRINT OR TYPE)	TITLE	DAYTIME TELEPHONE NUMBER

SIGNATURE OF POLICYHOLDER REPRESENTATIVE	DATE

SECTION B - MUST BE COMPLETED

LIST NAME, ADDRESS, AND PHONE # OF OTHER INSURANCE COMPANIES UNDER WHICH CLAIMANT IS INSURED:	POLICY #/ACCOUNT #

IF CLAIMANT IS A MINOR, NAME OF CLAIMANT'S GUARDIAN/RELATIONSHIP TO CLAIMANT

ADDRESS OF CLAIMANT (IF CLAIMANT IS A MINOR, NAME AND ADDRESS OF CLAIMANT'S GUARDIAN)	GUARDIAN'S SOCIAL SECURITY NUMBER

NAME/ADDRESS/TELEPHONE # OF EMPLOYER (IF CLAIMANT IS A MINOR, GUARDIAN'S EMPLOYER)	EMPLOYER'S DAYTIME TELEPHONE #

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

AUTHORIZATION and ASSIGNMENT OF BENEFITS

I, the undersigned authorize any hospital or other medical-care institution, physician or other medical professional, pharmacy, insurance support organization, governmental agency, group policyholder, insurance company, association, employer or benefit plan administrator to furnish to the Insurance Company named above or its representatives, any and all information with respect to any injury or sickness suffered by, the medical history of, or any consultation, prescription or treatment provided to, the person whose death, injury, sickness or loss is the basis of claim and copies of all of that person's hospital or medical records, including information relating to mental illness and use of drugs and alcohol, to determine eligibility for benefit payments under the Policy Number identified above. I authorize the group policyholder, employer or benefit plan administrator to provide the Insurance Company named above with financial and employment-related information. I understand that this authorization is valid for the term of coverage of the Policy identified above and that a copy of this authorization shall be considered as valid as the original. I understand that I or my authorized representative may request a copy of this authorization.

I authorize payment of medical benefits to the physician or supplier for service performed. ☐ Yes ☐ No

CALIFORNIA:For your protection, California law requires the following to appear on this form: Any person who knowingly presents a 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 New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the subject motor vehicle or stated claim for each such violation.
For residents of Pennsylvania: 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 and subjects such person to criminal and civil penalties.
For claimants not residing in California, New York, or Pennsylvania: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

CLAIMANT OR AUTHORIZED PERSON'S SIGNATURE	DATE