How to File a Claim

1. Obtain a claim form from your school office. All lines must be completely filled out.
2. Send original itemized bills with diagnosis and the corresponding explanation of benefits notice from your primary carrier. (keep copies for your records)
3. Mail completed form to: Hazelrigg Claims Management Services, 15345 Fairfield Ave., Suite 250, Chino Hills, CA 91709
4. If you already paid the doctor or hospital, include a paid receipt and/or a copy of your cancelled check.
5. Attach itemized bill to completed claim form. An itemized bill **must** include:
   a. School District Name
   b. Patient's name
   c. Patient's complete address
   d. Diagnosis
   e. Date of service(s)
   f. Description of treatment (i.e. type of x-ray, office visit, lab test, etc.)
   g. Doctor's/Hospital name, address and telephone number
6. If you have other bills, such as x-rays or laboratory charges, be sure to attach these original itemized bills and corresponding Explanation of Benefits Notice from your primary carrier to the claim form. Send your claim form and all of the itemized bills as directed on the reverse side of this form. Attach all of your bills for injury to the same claim form.
7. Please do not send bills without a completed claim form. The bills will not be processed with partial information.

Exclusions

No Benefits are payable for Hospital and Professional Services for the following:

1. Injuries which are not caused by an Accident.
2. Injury sustained as a result of operating, riding in or upon, or alighting from a two, three, or four wheeled recreational motor vehicle or snowmobile.
3. Re-injury or complications of a condition for which medical advice or treatment was recommended by a physician or received from a physician within a 6-month period preceding the effective date of individual insurance.
4. Injury due to acts of war, suicide or intentionally self-inflicted injury, while sane or insane, violating or attempting to violate the law, taking part in any illegal activity, fighting or brawling, except in self-defense, or being legally intoxicated or being under the influence of alcohol as defined by the California law; or under the influence of any drugs or narcotics unless administered, prescribed or on the advice of a physician.
5. Treatment performed by a member of the student's immediate family or by a person employed by the school district.
6. Treatment for hernia, regardless of cause, Osgood Schlatter's disease, fibromyalgia or osteochondritis.
7. Medical expenses for which the insured is entitled to benefits under any (a) workers' compensation act or (b) mandatory no-fault automobile insurance contract.
8. Expense incurred for treatment or temporomandibular joint dysfunction and associated myofacial pain.

Temple City Unified School District

2019 - 2020

Important Information About Your Child's Supplemental Student Accident Insurance

Coverage Provided Through:
West San Gabriel Liability and Property Joint Powers Authority

If you have any questions, please contact
Hazelrigg Claims Management Services: (909) 259-9948

BENEFITS

Service	Benefit
PHYSICIANS SERVICES	
Surgical	100% Reasonable Expenses
Anesthesiologist or Assistant Surgeon (each)	25% of Surgical Allowance
Physician's Non-Surgical Treatment (except as below)	100% Reasonable Expenses
Physician's Inpatient/Outpatient Treatment in Connection with Physical Therapy and/or Spinal Manipulation	100% Reasonable Expenses Inpatient; Maximum $1,200 Outpatient
Consultants (when required by attending physician for confirming or determining a diagnosis but not for treatment) and Second Opinions	100% Reasonable Expenses
HOSPITAL/FACILITY SERVICES	
Inpatient	
Hospital Room & Board – Semi-Private	100% Reasonable Expenses
Hospital Intensive Care	100% Reasonable Expenses
Hospital Inpatient Miscellaneous	100% Reasonable Expenses
Outpatient	
Outpatient Hospital Miscellaneous – (except physician's services and x-rays paid as below)	100% Reasonable Expenses
Hospital Emergency Room	100% Reasonable Expenses
Free-Standing Ambulatory Surgical Facility	100% Reasonable Expenses
OTHER SERVICES	
X-Rays Includes Interpretation	100% Reasonable Expenses
Diagnostic Imaging (MRI, CAT Scan, etc.) Includes Interpretation	100% Reasonable Expenses
Registered Nurses' Services	100% Reasonable Expenses
Prescriptions – Outpatient	100% Reasonable Expenses
Laboratory Tests – Outpatient	100% Reasonable Expenses
Ground or Air Ambulance	100% Reasonable Expenses
Durable Medical Equipment Includes Orthopedic Braces and Appliances	100% Reasonable Expenses, $1,200 Maximum
Replacement or Eyeglasses, Hearing Aids, Contact Lenses (if medical treatment is also received for a covered injury)	100% Reasonable Expenses
DENTAL SERVICES	
Treatment, Repair or replacement of Injured Natural Teeth, Includes Initial Braces When Required for Treatment of a Covered Injury, as Well as Examination, X-rays, Restorative Treatment, Endodontics, Oral Surgery and Treatment for Gingivitis Resulting From Trauma	Reasonable Expenses Up to Policy Maximum
ADDITIONAL EXTENDED DENTAL SERVICES	
Replacement of Caps, Crowns, Dentures and Orthodontic Appliances (including braces) When Damaged in a Covered Accident	Reasonable Expenses Up to Policy Maximum

POLICY MAXIMUM IS $5,000 AGGREGATE PER CLAIM

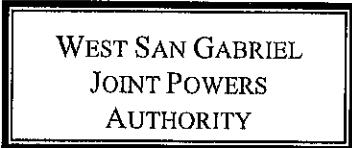
All Students are covered for injury during the hours and days when school is in session and while attending or participating in a school sponsored and supervised activities on or off school premises.

This insurance is in **excess** to all other valid and collectible insurance. All claims made are paid on a Non-Duplication, Excess or Secondary basis. This program will only pay for those expenses and deductibles not paid or payable by any other valid and collectible insurance, HMO, PPO, or self-insured plan, which may cover the student. If it is shown that the insured has no other medical coverage, this plan will pay as if it is a primary policy up to $5,000 aggregate. If the student has any other insurance, file simultaneous claims with that carrier to avoid delays in payment.

A Supplemental Student Accident Claim Form must be sent within 90 days of the date you first received medical care. If you did not sign the form to pay benefits to provider, you must include original receipts for each paid bill. Keep copies of all claim forms, bills and correspondence for your own records until your claim has been processed.

If, within 180 days from the date of a covered injury, the student receives (under the care of a licensed physician) any of the following medical services, the coverage will pay the reasonable expenses actually incurred within 52 weeks from the date of first treatment for such covered injury up to the program limits, but not to exceed the medical expense of $5,000 aggregate per claim.

SUPPLEMENTAL STUDENT ACCIDENT CLAIM FORM



SEND YOUR CLAIM FORM TO: **Hazelrigg Claims Management Services,**
15345 Fairfield Ave., Suite 250, Chino Hills, CA 91709

SCHOOL INFORMATION

(1) School District
(2) School Site
(3) School Address
(4) School Phone Number
(5) At the Time of Injury, was the Student Involved in a School Sponsored & Supervised Activity? Yes ☐ No ☐
(6) If Athletics, Designate: PE Class ☐ Intramurals ☐ Interscholastic ☐ Practice ☐
(7) Type of Sport
(8) Under Whose Supervision?
(9) Was Accident Witnessed? Yes ☐ No ☐
(10) By Whom
(11) Signature: (Must be signed by school official) Title Date

STUDENT INFORMATION

(12) Student Name (Last) (First) (Middle Initial)
(13) Social Security Number
(14) Female ☐ Male ☐
(15) Birth Date
(16) Grade
(17) Time of Injury
(18) Date of Injury
(19) Where did Injury Occur?
(20) Date of First Treatment
(21) By Whom
(22) Part of Body Injured
(23) How did Injury Occur?

PARENT OR GUARDIAN INFORMATION

(24) Father's Name
(25) Social Security Number
(26) Mother's Name
(27) Social Security Number
(28) Home Address (Street) (City) (State) (Zip) (Phone Number)
(29) Father's Employer
(30) Employer's Phone Number
(31) Employer's Address
(32) Is There Any Medical Insurance Provided by the Employer for the Injured Student? Yes ☐ No ☐
(33) Name and Address of Insurance Referenced in #32 (must be completed)
(34) Policy Number Individual ☐ Group ☐ Other ☐
(35) Mother's Employer
(36) Employer's Phone Number
(37) Employer's Address
(38) Is There Any Medical Insurance Provided by the Employer for the Injured Student? Yes ☐ No ☐
(39) Name and Address of Insurance Referenced in #38 (must be completed)
(40) Policy Number Individual ☐ Group ☐ Other ☐

I hereby authorize any insurance company, hospital, physician, employer or other person who has attended or examined the claimant to disclose when requested to do so all information with respect to any injury, policy coverages, medical history, consultations, prescription or treatment, and copies of all hospital or medical records and itemized bills. A photostatic copy of this authorization shall be considered as effective and valid as the original. I swear that the above information is true and correct to the best of my knowledge and further understand that it is a criminal offense to knowingly file a statement of claim containing false or misleading information or to willfully conceal information thereto with the intent to defraud an insurance company.

(Date) (Signature of Responsible Party or Student if 18 years old)

AUTHORIZATION TO PAY BENEFITS TO PROVIDER: I hereby authorize payment directly to the Provider of Surgical and/or Medical benefits, if any, otherwise payable to me for services rendered but not to exceed the reasonable and customary charge for those services.

(Date) (Signature of Responsible Party or Student if 18 years old)

IMPORTANT NOTICE

This insurance is **excess** to all other valid and collectible insurance. If you have other medical insurance, submit your claim to your other insurer. When you receive their Benefit Statement, send it to us along with your itemized bills and this completed claim form. Please print or type. If this claim form is not completed in FULL, this claim form will not be processed and will be returned.

HOW TO FILE A CLAIM FORM

THIS CLAIM FORM MUST BE SENT WITHIN 90 DAYS OF THE DATE YOU FIRST RECEIVED MEDICAL CARE. IF YOU DID NOT SIGN THE REVERSE SIDE TO PAY BENEFITS TO PROVIDER, YOU MUST INCLUDE ORIGINAL RECEIPTS FOR EACH PAID BILL. KEEP COPIES OF ALL CLAIM FORMS, BILLS AND CORRESPONDENCE FOR YOUR OWN RECORDS UNTIL YOUR CLAIM HAS BEEN PROCESSED.

PLEASE FOLLOW THESE INSTRUCTIONS:

1. All lines must be completely filled out and be sure to sign the Medical Authorization.
2. Send **ORIGINAL ITEMIZED BILLS** with diagnosis and the corresponding **EXPLANATION OF BENEFITS NOTICE FROM YOUR PRIMARY CARRIER**. (keep copies for your records)
3. Mail completed form to **Hazelrigg Claims Management Services, 15345 Fairfield Ave., Suite 250, Chino Hills, CA 91709**
4. If you already paid the doctor or hospital, include a paid receipt and/or a copy of your cancelled check.
5. Attach itemized bill to completed claim form. An itemized bill **must** include:
   a. School District Name
   b. Patient's name
   c. Patient's complete address
   d. Diagnosis
   e. Date of service(s)
   f. Description of treatment (i.e. type of x-ray, office visit, lab test, etc.)
   g. Doctor's/Hospital name, address and telephone number
6. If you have other bills, such as x-rays or laboratory charges, be sure to attach these original itemized bills and corresponding Explanation of Benefits Notice from your primary carrier to the claim form. Send your claim form and all of the itemized bills as directed on the reverse side of this form. Attach all of your bills for injury to the same claim form.
7. Please do not send bills without a completed claim form. The bills will not be processed with partial information.
8. EXCLUSIONS: No Benefits are payable for Hospital and Professional Services for the following:
   a. Injuries which are not caused by an Accident.
   b. Injury sustained as a result of operating, riding in or upon, or alighting from a two, three, or four wheeled recreational motor vehicle or snowmobile.
   c. Re-injury or complications of a condition for which medical advice or treatment was recommended by a physician or received from a physician within a 6-month period preceding the effective date of individual insurance.
   d. Injury due to acts of war, suicide or intentionally self-inflicted injury, while sane or insane, violating or attempting to violate the law, taking part in any illegal activity, fighting or brawling, except in self-defense, or being legally intoxicated or being under the influence of alcohol or under the influence of any drugs or narcotics unless administered, prescribed or on the advice of a physician.
   e. Treatment performed by a member of the student's immediate family or by a person employed by the school district.
   f. Treatment for hernia, regardless of cause, Osgood Schlatter's disease, fibromyalgia or osteochondritis.
   g. Medical expenses for which the insured is entitled to benefits under any (a) workers' compensation act or (b) mandatory no-fault automobile insurance contract.
   h. Expense incurred for treatment or temporomandibular joint dysfunction and associated myofacial pain.

FRAUDULENT CLAIM DISCLOSURE

Any incorrect, misleading or undisclosed information regarding other insurance coverage can result in duplicate payments creating a substantial overpayment. Any person who, knowingly and with intent to defraud, files a statement of claim containing materially false information or conceals information concerning any material fact, commits fraudulent insurance act, which is a federal offense. Any attempt to collect full primary benefits in excess of the total covered expenses under two or more group insurance plans is considered mail fraud and will fall under federal jurisdiction.