



Gerber Life Insurance Company

CLAIM FORM
SIGNED CLAIM FORM IS REQUIRED

SEND ALL CORRESPONDENCE TO:

WEB-TPA
P.O. Box 2415
Grapevine, TX 76099-2415
Toll-Free: 866-975-9468
Fax: 469-417-1969

IMPORTANT NOTICE:

Your insurance plan is designed to provide maximum benefits for minimum premium. This plan of insurance is secondary to any health insurance you have. If you have other insurance, submit your claim to your other insurer. When you receive their Benefit Statement, send it to us along with your itemized bills, with diagnosis, and this completed form. SEE REVERSE SIDE FOR ADDITIONAL INSTRUCTIONS ON FILING A CLAIM. Note: The accident policy benefits are limited and may not provide 100% coverage.

< IF PART 1-A & PART 1-B ARE NOT COMPLETED IN FULL THIS CLAIM CANNOT BE PROCESSED AND WILL BE RETURNED >

PART 1-A - TO BE COMPLETED IN FULL BY THE ORGANIZATION/SCHOOL

Organization/School District/College Name Columbia School District Policy Number 24-7077-13
School/Team/League Name Phone No. ()
Address Email
Type of Activity/Sport
If Athletics, designate P.E. Class Intramural Interscholastic Intercollegiate Game Jr. Varsity Varsity
Youth Adult Practice Other
Date of Accident Accident Time Date of First Treatment
Where and how did accident occur? (Please be specific)

Part of body Injured At the time of the accident, was the claimant involved in a sponsored and supervised activity and were they a current student/member of the Organization/School District? Yes No
Under whose supervision? Was he/she a witness? Yes No
Authorized Signature Title Date
(MUST BE SIGNED BY AN ORGANIZATION/SCHOOL OFFICIAL UNLESS INJURY DID NOT OCCUR DURING AN ORGANIZATION/SCHOOL ACTIVITY. SIGNATURE IS REQUIRED)

PART 1-B - TO BE COMPLETED IN FULL BY CLAIMANT - OR BY PARENT/LEGAL GUARDIAN IF CLAIMANT IS A MINOR

Claimant's Name Social Security #
Date of Birth Age Grade Level Male Female
Claimant is a Student Player Coach Official/Umpire Volunteer Day Care Participant CE Student (# of credits)
Address of Claimant or Parents/Guardian
Phone No. () Email Address
Name and Address of Family Physician
Phone No. () Has treatment been completed? Yes No
Claimant or Father/Guardian Name
Employer Name and Address Phone No. ()
Self Employed Unemployed
Claimant or Mother/Guardian Name
Employer Name and Address Phone No. ()
Self Employed Unemployed
Is claimant covered under any other medical and or dental insurance policy? Yes No
Is claimant covered under a government sponsored insurance such as Medicare/Medicaid? Yes No

PLEASE CONTINUE TO THE NEXT PAGE OF THE FORM WHICH MUST BE COMPLETED IN FULL

Name of all companies providing claimant insurance coverage or prepaid health plans

Name of Company

Address

Policy #

Are benefits due for this claim under these other insurance coverages? Yes No (See IMPORTANT NOTICE at top of form on page 1)

Does your son or daughter have medical insurance coverage as an eligible dependent from a previous marriage as mandated in a divorce decree? Yes No If yes, please give name, address and phone number of responsible party _____

AFFIDAVIT: I verify that the above statement on other insurance is accurate and complete. I understand that the intentional furnishing of incorrect information via the U.S. Mail may be fraudulent and violate federal laws as well as state laws. I agree that it is determined at a later date that there are other insurance benefits collectible on this claim I will reimburse Gerber Life Insurance Company to the extent for which Gerber Life Insurance Company would not have been liable.

Signature: Claimant, Parent or Guardian _____ Date: _____

SIGNATURE IS REQUIRED

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize any employer, health plan, insurance company, hospital, physician, health care profession, clinic, laboratory, pharmacy, medical facility or other person that has provided treatment, payment, or services in connection with this claim to disclose, when requested to do so, all information with respect to any injury, policy coverage, medical history, consultations, prescription or treatment, and copies of all hospital or medical records and itemized bills to WebTPA, Inc. and Gerber Life Insurance Company, it's agents, employees and representatives.

I hereby authorize WebTPA, Inc. to discuss any information related to medical expenses incurred or treatments rendered in connection with this claim, with Special Markets Insurance Consultants, Inc. representatives and their assigned agents and to officials at the school or organization through which this policy is issued. A photo static copy of this authorization shall be considered as effective and valid as the original.

Signature: Claimant, Parent or Guardian _____ Date: _____

PLEASE READ

PLEASE FOLLOW THESE INSTRUCTIONS TO FILE A CLAIM

ALL INFORMATION MUST BE PROVIDED IN ORDER FOR CLAIM TO BE PROCESSED

NOTE: The accident policy benefits are limited and may not provide 100% coverage. Completion of a claim form does not guarantee benefit payment. Each claim is reviewed according to the policy provisions.

- ◆ Answer all questions in detail (including all signatures on the front and back of the form). A claim form needs to be completed for each accident.
- ◆ If you have other insurance, submit your claim to your other insurer. When you receive the explanation of benefits notice from your primary carrier, send it to us along with the corresponding itemized bills and with the fully completed claim form. You must submit itemized bills; balance due statements will not be processed. Itemized bills include:
 - 1) HCFA-1500 (standard form used by Providers)
 - 2) UB-04 or UB-92 (standard form used by Hospitals)
- ◆ If you already paid the bill, include a paid receipt or a copy of your cancelled check. Otherwise payment will be made to the providers of service (Hospital, Physician or Others), unless a paid receipt statement accompanies the bill at the time the claim is submitted.
- ◆ Send all correspondence to WebTPA, Inc., P.O. Box 2415 Grapevine, TX 76099-2415. The claim form must be sent within 90 days of the date you first received medical care. Any bills not filed with the claim form should be sent, within 90 days of the date you received medical care, to the Company identified with claimant's name, Organization or School name and date of Accident.
- ◆ If you change your address, please notify WebTPA, Inc. by sending notification to WebTPA so that there is no delay in processing any claims.
- ◆ Please contact WebTPA, Inc. by calling 866-975-9468 if you would like to check the status of your claim or if you have any questions on how your claim was processed or the benefit paid.

Common Causes For Delays In Processing Claims

1. Claim Forms Not Completed In Full or Not Submitted.
2. Balance Due, Balance Forward, or Past Due Statements Submitted for Bills.
3. Explanation of Benefits from Primary Carrier Not Provided with the Bills.

KEEP COPIES OF ALL CLAIM FORMS, BILLS, AND CORRESPONDENCE FOR YOUR OWN RECORDS UNTIL YOUR CLAIM HAS BEEN PROCESSED.