Gerber Life Insurance Company

STUDENT ACCIDENT INSURANCE CLAIM FORM
SIGNED CLAIM FORM IS REQUIRED

1. PLEASE FULLY COMPLETE THIS FORM PAGE 1 & PAGE 2
2. ATTACH ITEMIZED BILLS & EOBS FROM PRIMARY CARRIER
3. SEE REVERSE SIDE FOR ADDITIONAL INSTRUCTIONS
4. SEND ALL CORRESPONDENCE TO:

WEB-TPA
P.O. Box 2415
Grapevine, TX 76099-2415

Toll-Free: 866-975-9468
Email: helpme@webtpa.com

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 Name Mt Zion CUSD #3 Policy Number 13-4088-15

School Name _____ Phone No. ( )_____

Address _____ Email _____

_____ Type of Activity/Sport _____

If Athletics, designate ☐P.E. Class ☐Intramural ☐Interscholastic ☐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

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. Non-compliance with your primary health HMO/PPO plan will reduce this plans benefits by 50%. 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. <u>You must submit itemized bills; balance due statements will not be processed</u>. 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.