PO Box 15369
Springfield, MA 01115-5369
(877) 657-5039
specialriskCS@wellfleetinsurance.com
fax: (413) 733-4612

PLEASE FULLY COMPLETE THIS FORM

ATTACH ITEMIZED BILLS

MAIL ALL INFORMATION TO THE ABOVE ADDRESS

PART I – POLICYHOLDER'S REPORT

Participating Group Number:	Policyholder Number:	Policyholder Name:	Event, Activity or Sport
SR511399K2	MP0000700782	Regional School District #15 Inc. Towns Middlebury and Southbury	

Claimant's Name (Injured Person)	Social Security Number	Gender ☐ M ☐ F	Date of Birth	E-Mail Address

Address of Injured Person and Best Contact Phone Number (Include Area Code)

Date and Time of Accident	Place where Accident Occurred	The injured person was a: ☐ Participant ☐ Staff Member ☐ Other

Dental Claim	Indicate which Teeth were Involved in the Accident	Describe Condition of Injured Teeth Prior to Accident: ☐ Whole, Sound & Natural ☐ Filled ☐ Capped ☐ Artificial

Type of Injury (Indicate Part of Body Injured – e.g. broken arm, sprained ankle, etc.)

Did Injury Result in Death? ☐ Yes ☐ No

Describe How Accident Occurred – Give All Possible Details

Did Accident Occur (Check Yes or No for Each of the Following):

A. During a policyholder programmed, sponsored & supervised, or sanctioned activity? ☐ Yes ☐ No

B. On activity premises? ☐ Yes ☐ No

C. While traveling directly and uninterruptedly to or from the event? ☐ Yes ☐ No

D. During intercollegiate/scholastic athletic practice or competition? ☐ Yes ☐ No

I certify that the above information is correct to the best of my knowledge and belief, that the person named above is insured by the policy, and that his or her insurance was in effect on the date the accident occurred.

Signature of Plan Sponsor	Name, Title and Telephone Number of Plan Sponsor	Date

PART II – OTHER INSURANCE STATEMENT

Do you/spouse/parent have medical/health care or are you enrolled as an individual, employee or dependent member of a Health Maintenance Organization (HMO) or similar prepaid health care plan, or any other type of accident/health/sickness plan coverage through an employer, a parent's employer or other source? ☐ Yes ☐ No

If yes name of insurance company: ______________________ Policy #: ______________________

Other Insurance Carrier ID# ______________________ Other Insurance Carrier Telephone# ______________________

Mother's (Guardian's) primary employer name, address & telephone: ______________________

Father's (Guardian's) primary employer name, address & telephone: ______________________

Are you eligible to receive benefits under any governmental plan or program, including Medicare?

☐ Yes ☐ No If yes, please explain: ______________________

IF OTHER INSURI IF OTHER INSURANCE OR HEALTH CARE PLANS EXIST, PLEASE SUBMIT COPIES of their EXPLANATION OF BENEFITS along with your claim.

I agree that should it be determined at a later date there is another insurance (or similar), to reimburse Wellfleet Group to the extent of any amount collectible.

SIGNATURE ______________________ DATE ______________________

PART III – AUTHORIZATION TO PAY BENEFITS TO PROVIDER

I authorize medical payments to physician or supplier for services described on any attached statements enclosed. If not signed, please provide proof of payment.

SIGNATURE ______________________ DATE ______________________

I authorize any physician, medical professional, hospital, covered entity as defined under HIPAA, insurer or other organization or person having any records, dates or informati concerning the claimant to disclose when requested to do so, all information with respect to any injury, policy coverage, medical history, consultation, prescription or treatment and copies of all hospital or medical records or all such records in their entirety to Wellfleet Group, LLC. A photo static copy of this authorization shall be considered as effective and valid as the original.

I agree that should it be determined at a later date there is other insurance (or similar), to reimburse Wellfleet Group to the extent of any amount collectible.

I certify that the above information is correct to the best of my knowledge and belief. I understand that any person who knowingly and with the intent to defraud or deceive any insurance company; files a claim containing any material by false, incomplete or misleading information may be subject to prosecution for insurance fraud.

SIGNATURE ______________________ DATE ______________________