STUDENT ACCIDENT FORM (SAF)

PLEASE READ!

PARENT/LEGAL GUARDIAN IS RESPONSIBLE FOR SUBMITTING THIS FORM WITHIN 90 DAYS FROM THE INITIAL DATE OF INJURY!

DO NOT WAIT FOR THE PROVIDER(S) TO BILL YOU BEFORE SUBMITTING THIS FORM!

ADL RISK SERVICES, LLC

This form must be completed in its entirety and submitted to ADL Risk Services (ADL) on or after the date of injury, and no later than ninety (90) days from the initial date of injury, to avoid denial of the claim. Expenses eligible for benefits/coverage will be paid only when they exceed other valid insurance. Your medical provider must file your claim with all other available and collectible insurance before filing it with the ADL. Please provide all medical providers where treatment was or will be received with the billing address and contact information for ADL Risk Services, such as your secondary, excess, student accident medical insurance, to be billed directly once any applicable primary or other insurance has been paid. The medical provider must submit the HCFA 1500 and/or UB-04 form along with the Explanation of Benefits (EOB) from your primary insurance. Please read the Instructions for Filing Medical Claims for Accidents carefully before submitting this form or filing any claims. Instructions for filing the claim are included with the student accident form that has been provided to the School District(s).

NOTE: To avoid denial of your claim(s), please ensure that you meet the above and following criteria. Medical treatment must begin within 30 days of the initial date of injury by a licensed physician. (Or within 72 hours, if emergency room treatment is required.) Each injury has a benefit eligibility period of one year (52 weeks). All medical claims must be filed as soon as possible and no later than 180 days after the injury benefit period ends, or your claim(s) will be denied. Student Accident Plan benefits are limited and may not provide 100% coverage, especially if your primary insurance's annual deductible or coinsurance requirements have not been met. This is a Student Accident Excess Benefit Plan, NOT a comprehensive health insurance plan/policy for major medical expenses or an alternative to a health insurance plan/policy for major medical expenses. **Keep a copy of this form for your records.**

Section 1: School Notification of Injury Report

(Section 1: Must be completed and signed by an Authorized School official)

School District Name (*Plan holder*): TROUP COUNTY SD, GA

School District Plan ID/Policy#: GA2023-24-01-403

Name of school attended:

School Phone:

Injured Student's Name (***First Name, Middle Name, Last Name*):**

Social Security# *(Last Four):*

☐ Male ☐ Female

Date of birth:

Age:

Grade:

Date of injury:

Injured body part(s): ☐ **left** ☐ **right**

Place of injury:

Time of injury: ☐A.M.☐ P.M

Name of the activity or sport:

At the time the injury occurred, was the accident witnessed? ☐ Yes ☐ No
If so, by whom?

At the time of the accident, was the student engaged in an activity sponsored and supervised by the Plan Holder? ☐ Yes ☐ No

At the time of the accident, was the student traveling to or from a school activity? ☐ Yes ☐ No

How did the injury occur? ***(Explain in detail)***

School Official (printed):

Phone:

Title:

Email:

School Official's Signature:

Date signed:

Section 2: Student Insurance Information

(MUST be completed by the parent/legal guardian. If the student doesn't have insurance, write "None")

Is the student covered by any other insurance plan/policy, either as a dependent or under a group, individual, auto, medical, or liability policy? ☐ Yes ☐ No

Policyholder's Name:

Insurance carrier:	**Policy/Plan No:**

Is the student covered by both parent/guardian insurance plans? ☐ Yes ☐ No
(If yes, add policyholder's insurance information (2) below.)

Insurance Company Name (2):

Name of the insured (2):	*Policy/Plan No.:*

Is the above insurance a Medicaid or other government insurance?
☐ Yes ☐ No
*If the answer is "YES", enter the policy/plan number above.

Section 3: Parent/Guardian Statement

(Sections 2 and 3 MUST be completed by the parent/legal guardian)

Father/Legal Guardian's Name: (*Please write legibly*)

Father/Legal Guardian's phone no:	Father/Legal Guardian Email:
Does the father/legal guardian work? ☐ Yes ☐ No	Father/Guardian Employer:

Mother/Legal Guardian's Name: (***Please write legibly***)

Mother/Legal Guardian phone no.:	Mother/Legal Guardian Email:
Does the mother/legal guardian work? ☐Yes ☐ No	Mother/Legal Guardian Employer:

Parent/legal guardian's mailing address (*address, city, state, zip code*):

Section 4: AUTHORIZATION OF MEDICAL INFORMATION AND ASSIGNMENT OF BENEFITS

Must be signed by Parent/guardian.

AUTHORIZATION OF HEALTH INFORMATION AND ASSIGNMENT OF BENEFITS: I authorize any health care provider, medical facility, physician, insurance company, or organization to provide, upon request of ADL Risk Services, LLC or the underwriting companies with which it works, information it may possess, including findings and treatments rendered, and copies of all hospital and medical records of professional services and hospital care rendered in my name. The foregoing authorization is granted with the understanding that any legal rights you may normally have to claim communications between us as privileged are expressly and voluntarily waived. A photocopy of this authorization will be considered as valid and effective as the original. Payments will be made to service providers, unless a paid receipt/statement accompanies the submission of the medical claim. **Any person, who knowingly and with intent to harm, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information, is guilty of a felony.**

STUDENT NAME ***(in print):***	**PARENT/GUARDIAN SIGNATURE:**	**DATE SIGNED:**

ATTENTION: SEND THIS FORM AND MEDICAL CLAIMS TO:

ADL RISK SERVICES, LLC, *Plan Administrator*
PO Box 640789
Pike Road, AL 36064

Phone: 844.350.9897 ● Secure Fax 334.649.7901 ● *Email:* claims@adlrs.com ● Website: http://adlrs.com

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Compulsory