Berkley Accident and Health
a Berkley Company

STUDENT CLAIM FORM

1. Please fully complete this form
2. Attach itemized bills (UB04 or HCFA-1500 form)
3. Mail, Email or Fax to *HSR*
Email: K12claims@hsri.com

HSR
Health Special Risk, Inc.

P.O. Box 250649
Plano, Texas 75025-0649
Phone: (972) 512-5600
Fax: (972) 512-5818
Toll Free (866) 409-5734

School District:

School Name:

2025-26 SCHOOL YEAR

Insurance coverage is underwritten by Berkley Life and Health Insurance Company, (domiciled in Iowa - California Certificate of Authority #08527) or StarNet Insurance Company (domiciled in Iowa - California Certificate of Authority #6978), 2445 Kuser Road, Suite 201, Hamilton Square, NJ 08690.

ACCIDENT CLAIM FORM

PART I – POLICYHOLDER'S REPORT

1. Claimant's Name (injured/ill person)	2. Social Security Number	3. Gender ☐ M ☐ F	4. Date of Birth	5. E-Mail

6. Address of Injured Person	7. Phone Number (include area code)
8. Parent/Legal Guardian Name, Address, City, State & Zip	9. Phone Number (include area code)

10. Date of Accident/Illness	11. Time of Accident ☐ a.m. ☐ p.m.	12. Place where Accident Occurred	13. Date of First Treatment

Dental Claims	14. Indicate which Teeth were Involved in the Accident	15. Describe Condition of Injured Teeth Prior to Accident: ☐ Whole, Sound, and Natural ☐ Filled ☐ Capped ☐ Artificial

16. Type of Injury (Indicate Part of Body Injured – e.g., broken arm, sprained ankle, etc.) Did Injury Result in Death? ☐Yes ☐No

17. Describe How Accident Occurred or the Nature of the Illness – Give all possible details

18. Which Best Describes the Activity:		
☐ Play or practice of interscholastic sports	☐ During lunch hour	☐ Athletic period
☐ Not school related	☐ In school bus	☐ On school property during school hours
☐ P.E. class	☐ School sponsored field trip	☐ School sponsored activity during school hours
	☐ Traveling to/from school	☐ ROTC activity

19. Name of Person Supervising the Activity	20. If engaged in an Interscholastic Sport at the time of the injury, what was the sport?

Signature of Parent/Legal Guardian:	Signature of School Official:
X Date:	X Date:

PART II – OTHER INSURANCE STATEMENT

Do you/spouse/parent have medical/health care or is the Claimant 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 your employer or other source on you or, if applicable, does your son/daughter have health care coverage as a dependent from your previous marriage as mandated in a divorce decree? ☐ Yes ☐ No

If Yes, name of insurance company _____ Policy # _____

Name of insurance company _____ Policy # _____

If applicable, claimant's primary employer name, address, and phone number _____

If applicable, mother's primary employer name, address, and phone number _____

If applicable, father's primary employer name, address, and phone number _____

AUTHORIZATION TO PAY BENEFITS TO PROVIDER: I hereby authorize medical payments to be made directly to doctor(s), hospital(s), or indicated provider(s) of service(s) in connection with this claim. (If not signed submit proof of payment)

SIGNATURE _____ _____ **DATE** _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION: I hereby authorize any physician or medical practitioner, hospital, other organization, institution, or person that has any medical records or knowledge of me or my family as diagnosis, treatment, and prognosis regarding any physical, mental, drug or alcohol condition of any and all such information to be given to Berkley Group Companies: Berkley Life and Health Insurance Company, StarNet Insurance Company, or its authorized Administrators or their legal representatives.

Any information obtained will not be released by the Company, except to persons or organizations performing business or legal services in connection with my claim. A photocopy of this authorization shall be valid as the original and is valid for 24 months from the date shown below (In CA, CT, GA, HI, MA, MN, NC, NJ, OH, and VA authorization shall be valid during the duration of the claim). I understand that my authorized representative or I will receive a copy of this authorization upon request.

DECLARATION: These statements are true and complete to the best of my knowledge.

Warning: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **FOR RESIDENTS OF NEW YORK:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation. (Fraud language varies by state. Please see below.)

Printed Name of Claimant or Authorized Representative _____ Relationship _____

Signature of Claimant or Authorized Person _____ Date _____

By entering your name above in Part II, you are signing this claim form electronically. You agree your electronic signature is the legal equivalent of your manual/handwritten signature on this claim form.

** **Notice to CALIFORNIA RESIDENTS:**
Please refer to the attached Notice of Personal Information Collected pursuant to California Consumer Privacy Act (CCPA)

FRAUD WARNING

FOR RESIDENTS OF ALASKA: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

FOR RESIDENTS OF ARIZONA: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

FOR RESIDENTS OF CALIFORNIA: For your protection California law requires the following to appear on this form:

Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

FOR RESIDENTS OF COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard

to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

FOR RESIDENTS OF DELAWARE AND IDAHO: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information is guilty of a felony.

FOR RESIDENTS OF FLORIDA: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

FOR RESIDENTS OF INDIANA: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

FOR RESIDENTS OF KANSAS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of insurance fraud as determined by a court of law and may be subject to fines and confinement in prison.

FOR RESIDENTS OF KENTUCKY: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

FOR RESIDENTS OF MARYLAND: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

FOR RESIDENTS OF MAINE, TENNESSEE, VIRGINIA AND WASHINGTON: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

FOR RESIDENTS OF MINNESOTA: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

FOR RESIDENTS OF NEW HAMPSHIRE: Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

FOR RESIDENTS OF NEW JERSEY: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

FOR RESIDENTS OF NEW MEXICO: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

FOR RESIDENTS OF OHIO AND OKLAHOMA: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

FOR RESIDENTS OF OREGON: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

FOR RESIDENTS OF PENNSYLVANIA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

FOR RESIDENTS OF PENNSYLVANIA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

FOR RESIDENTS OF VERMONT: Any person who knowingly presents a false statement in a claim for proceeds of an insurance policy may be guilty of a criminal offense and subject to penalties under state law.

Listed below are important instructions and comments about filing a claim.

YOUR CLAIM FORM

1. This claim form should be fully completed and submitted within 90 days from the date of injury. Be sure to answer and complete the section regarding "**OTHER INSURANCE STATEMENT**", marking either yes or no, and signing the line for authorization, so that ***HSR*** and the doctors/hospital may communicate concerning your claim.
   Incomplete claim forms are one of the most frequent reasons why claim payments are delayed.

2. Only one claim form for each accident needs to be submitted.

3. Once completed, make a photocopy for your records, and mail to the address shown below.

4. DO NOT assume that anyone else will mail this claim form to ***HSR*** for you.

YOUR BILLS

1. Please advise all doctors/hospitals regarding this coverage so they may forward us their itemized bills.

2. If you have already been to the doctor/hospital and did not know about this coverage, then please send all the itemized bills to ***HSR*** at the address shown below.

3. **The bills should include the name of the doctor/hospital, their complete mailing address, telephone number, the date you were seen by the doctor/hospital, what the doctor saw you for (diagnosis) and the specific itemized charges (description of treatment including the CPT/procedure code). Contact your medical provider for a UB04 or HCFA 1500 billing form.**
4. Due to HIPAA Privacy laws ***HSR*** is unable to request this information from your medical provider. Ultimately, it is your responsibility to provide the proper documentation. "Balance Due" or "Balance Forward" statements do not contain sufficient information to complete your claim. ***HSR*** cannot pay your bills using only the Primary Insurance Carrier's EOB.

EXCESS INSURANCE

1. If the policy provides coverage on a secondary/excess basis and you have any other primary insurance coverage you need to send the bills to your primary insurance first.

2. ***HSR*** will consider benefits after your primary insurance has processed the claim.

3. We will require a copy of your primary insurance Explanation of Benefits (EOB) which you should receive from your primary insurance letting you know what was paid or denied, and the reason(s) why.

4. ***HSR*** will not be able to consider your claim without this information.

If you have any questions, please contact Customer Service at (866) 409-5734. They are available from 8:00 a.m. to 5:00 p.m. Central Time, Monday – Friday. You may also forward any documents by fax to (972) 512-5818 or email to K12claims@hsri.com.

Health Special Risk, Inc.
P.O. Box 250649
Plano, Texas 75025-0649