PHILADELPHIA
INSURANCE COMPANIES

A Member of the Tokio Marine Group

ACCIDENT INSURANCE
INSTRUCTIONS FOR FILING A CLAIM – FULL EXCESS PLANS ONLY

The accident insurance plan is designed to cover all registered participants of the policyholder while they're engaged in policyholder sponsored and supervised activities. The plan will consider reimbursement for eligible expenses which are not payable by your healthcare plan or any other insurance plan providing reimbursement for medical expenses. Therefore, prior to filing a claim against the accident insurance policy, you must first file the claim with your own healthcare plan. Please observe the following claim filing procedures: **(Please include the policy number on all correspondence to facilitate the handling of your claim)**

1. Obtain a claim form from the sponsoring organization. Only one form is needed for each accident, regardless of the number of expenses incurred for the particular accident.

2. Part I of the claim form should be completed and signed by an official from the sponsoring organization. Part I requests a description of how the accident occurred. Please check to see that a complete description is provided. For example, "Basketball" is not acceptable; however, "Twisted left ankle while playing basketball" is acceptable.

3. Part II of the claim form should be completed and signed by the claimant or the claimant's parent or guardian if claimant is a minor. All questions in Part II must be completed in order for the company to examine your claim. Please do not leave any questions blank. Part II includes the section entitled "Authorization to Release Information."

4. Itemized Bills must be submitted. Itemized Bills provide the dates of service, the procedure codes, the diagnosis and the charge(s). "Balance Due" bills are not acceptable because they do not provide all of the information needed to properly examine a claim.

5. When submitting charges for Physical Therapy, the itemized bill must be accompanied by the prescription and include the frequency and the duration of the treatment.

6. Submit copies of the Explanation of Benefits (EOB) statements from your own healthcare plan. The EOB's will show how much your healthcare plan paid for the services rendered and the amount which is your responsibility. There should be an EOB for each Itemized Bill you have submitted for reimbursement.

7. Mail or email the fully completed claim form, each Itemized Bill (and the prescription, if applicable) and the corresponding EOB to the following address: **(Please include the Policy Number on all correspondence)**

NAHGA Claim Services
P.O. Box 189
Bridgton, ME 04009
claims@nahga.com
Fax 207-647-4569
Phone 800-952-4320

Please remember, the policy is an Accident insurance policy. It does not provide reimbursement for illness or for injuries that are not the result of an Accident. It is subject to exclusions and limitations. The policy may also contain a deductible which may be the claimant's responsibility. Please be aware that the claim form contains state mandated fraud warning language that requires your review and signature.

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ACCIDENT CLAIM FORM

MAIL TO: NAHGA Claim Services
P.O. Box 189
Bridgton, ME 04009
Email: claims@nahga.com
File claims electronically: Payer ID 67788 Questions: Contact 800-952-4320 Fax: 207-647-4569

INSTRUCTIONS *(SIGNATURE SECTION MUST BE COMPLETED AT THE BOTTOM OF PAGE ONE & TWO)*

- All fields must be completed (**Pages one and two must be signed and dated.**)
- Part I – Must be completed by Policyholder
- Part II – Must be completed by Claimant or by the Parent or Guardian, if the Claimant is a minor
- Send copies of itemized bills showing provider's name, address, tax ID number, diagnosis and procedures codes.
- Attach explanation of benefits, additional bills with record of payment or denial from primary insurance carrier.This does not apply if the accident policy provides primary coverage
- All benefits will be payable to the physicians and providers, unless accompanied by paid receipts

**For additional instructions about how to file a claim, please send an email to AH@phly.com

PART I – POLICYHOLDER REPORT (Signature is required at the end of this section)

1. Policy Number:_____
2. Name of Policyholder:_____
3. Policyholder Address:_____
4. City:_____ State:_____ Zip:_____
5. Policyholder Contact:_____ Email:_____
   Phone:_____ Fax:_____
6. Last name of Claimant:_____ First name of Claimant:_____
7. Social Security Number:_____ Date of Birth: _____
8. If you are covered under Medicare, gender information (male/ female) is required by the federal government for reporting purposes.
   Sex: ☐Male ☐Female ☐ Prefer not to answer
9. Grade (if applicable):____ Check one (if applicable) ☐ Day School ☐Boarding
10. Nature of injury: **(Describe, fully indicate what part of the body was injured – e.g. broken arm, sprained ankle) Must be a bodily injury due to accident.**

_____

11. Describe how the accident occurred, provide all details.
    Attach a separate sheet, if necessary (include name of sport/ activity)

_____

12. Did the accident occur:
    a. During a Policyholder supervised/ authorized activity? ☐Yes ☐No
    b. During a Policyholder sponsored activity? ☐Yes ☐No
    c. During scheduled Policyholder hours? ☐Yes ☐No
    d. While traveling to or from a Policyholder sponsored and supervised activity? ☐Yes ☐No
    e. Off Policyholder premises, at home, during the weekend, holiday or summer vacation? ☐Yes ☐No
13. Date of Accident:_____ Time of Accident:_____ ☐A.M. ☐P.M.
    Place of Accident:_____
14. Name and title of person supervising activity:_____
    Was he or she a witness? ☐Yes ☐No

_____ _____ _____

Signature of Authorized Policyholder Representative **Title** **Date**

PART II

(To Be Completed by Claimant or Parent/ Guardian if Claimant is a Minor)

1. Name of Claimant or Father/ Guardian:_____
   Social Security Number:_____ Email Address:_____
2. Name of Mother or Guardian:_____
   Social Security Number:_____ Email Address:_____
3. Street address of Claimant or Claimant Parent/ Guardian:_____
   City:_____ State:_____ Zip:_____
   Telephone Number:_____
4. Father or Guardian's Insurance Company:_____
5. Mother or Guardian's Insurance Company:_____
6. Name and address of Claimant or Father/ Guardian's employer, if a minor:_____
   Employer's Name:_____
   Employer's Mailing Address:_____
   City:_____ State:_____ Zip:_____
7. Name and address of Claimant or Mother/ Guardian's employer, if a minor:_____
   Employer's Name:_____
   Employer's Mailing Address:_____
   City:_____ State:_____ Zip:_____
8. Is the Claimant enrolled in, a member of, or a participant of any of the following as an individual, employee or dependent? If yes, please provide a copy of the insurance card (front and back).
   a. Preferred Provider Organization (PPO) or similar prepaid health plan? ☐Yes ☐No
      If yes, name of PPO Organization:_____
   b. Health Maintenance Organization (HMO) or similar prepaid health plan? ☐Yes ☐No
      If yes, name of HMO or organization:_____
   c. Medicare? ☐Yes ☐No
   d. Medicaid? ☐Yes ☐No
   e. Dental? ☐Yes ☐No

A SIGNATURE IS REQUIRED AT THE END OF THIS SECTION

AFFIDAVIT

I verify that the statement on the 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 if it is determined at a later date that there are other insurance benefits collectible on this claim I will reimburse the Company to the extent for which the Company would not have been liable.

AUTHORIZATION TO RELEASE INFORMATION

I authorize any Health Care Provider, Doctor, Medical Professional, Medical Facility, Insurance Company, person or Organization to release any information regarding medical, dental, mental, alcohol or drug abuse history, treatment or benefits payable, including disability or employment related information concerning the patient, to Philadelphia Indemnity Insurance Company, its employees and authorized agents for the purpose of validation and determining benefits payable. I further authorize any Philadelphia Indemnity Insurance Company Representative to furnish the Policyholder or its agents, any and all information with respect to my insurance claim for the purpose of assisting with claims adjudication. This data may be extracted for audit or statistical purposes. I understand that I have the right to revoke this authorization in writing at any time and that such a revocation is not effective to the extent that such authorization has already been relied upon.

PAYMENT AUTHORIZATION

I authorize all current and future medical benefits, for services rendered and billed as a result of this claim, to be made payable to the physicians and providers indicated on the invoices, unless paid receipts accompany this form.

NEW YORK FRAUD STATEMENT

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.

_____ _____

Claimant Signature (Parent or guardian, if the claimant is a minor) Date

Your signature above also acknowledges that you have read the below fraud statements.

CLAIM FORM FRAUD STATEMENTS

ALABAMA: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines or confinement in prison or any combination thereof.

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.

ARKANSAS, RHODE ISLAND AND WEST VIRGINIA: 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.

CALIFORNIA: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

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.

DELAWARE and IDAHO: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

DISTRICT OF COLUMBIA: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

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.

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.

KANSAS: Any person who, knowing and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.

KENTUCKY: Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

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.

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.

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

NEW HAMPSHIRE: Any person who, with a purpose to injure, defrauds, 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.

NEW JERSEY: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NORTH CAROLINA and OREGON: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, commits insurance fraud, which is a crime and subjects the person to civil and criminal penalties.

OHIO: 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.

OKLAHOMA: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

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.

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

THIS DOCUMENT MUST BE SIGNED AND DATED ON PAGES ONE AND TWO PRIOR TO SUBMITTING.