



# Voluntary Student Accident Medical Insurance

K-12 Schools 2025-26

## Accidents aren't supposed to happen, but they do.

School recess, after-school care, intercollegiate sports, field trips, and general school-related activities can all lead to unexpected injuries. Your school offers Voluntary Accident Insurance Plans, providing affordable protection during school hours or around the clock to ensure your loved ones get the care they need without financial hardship to your family. Choose from coverage options ranging from Low to High and find the plan that best fits your family's needs and budget.

## Any enrolled student is eligible for coverage.



School Time Accident Only



Optional Football Coverage



24-Hour Accident Only



24-Hour Dental

Voluntary Accident plans offered by your school are considered excess plans.

## Enrolling is easy and only takes a few minutes.

Go online at <https://bit.ly/3Q5hrzi>

1. Click on "Enroll Online".
2. Select your state and click "Look Up".
3. Select your school or district from the list.
4. Review the available plan options and make your selections.
5. Complete the online application.
6. Pay a one-time, annual cost via credit or debit card.
7. Print the confirmation of purchase as your proof of coverage.

## Filing a Claim:

**Complete the Gerber Life claim form with details of the injury and any additional insurance\***

- Access a claim form at [k12specialmarkets.com/claimforms](https://k12specialmarkets.com/claimforms).
- Select your state and click “Look Up” to select your school or district.
- Forms requires a parent and a school official’s signature. Be sure to include any information about private or additional insurance coverage, if applicable.
- Submit your completed form by mail, fax or electronically.
- An acknowledgment letter will be sent to the address on file, accompanied with a claim number.
- Reference your claim number when submitting any bills for treatment or medical care received from a provider.

*\* If you have private insurance, this voluntary accident plan will be secondary to your existing insurance. If you are covered by state-funded insurance (such as Medi-Cal/Medicaid, Medicare, or military insurance), or if you are uninsured, this plan will act as primary coverage and help cover eligible expenses.*

## About Student Insurance:

Since 1950, Student Insurance (SI) has delivered competitive pricing on comprehensive Student Accident Insurance coverage to the K-12 segment. SI is dedicated to helping families manage the unexpected costs of student injuries through flexible, easy-to-access coverage options. Comprehensive policy details regarding benefits, exclusions, and limitations are available by contacting your school or district office.

**Please note:** Students are able to purchase coverage only if their school district is a policyholder with the insurance company.

### How can we help?

Contact a Student Healthcare Expert at: [SIRep@studentinsuranceusa.com](mailto:SIRep@studentinsuranceusa.com) to learn more.

Student Insurance  
6320 Canoga Ave, 12th Floor  
Woodland Hills, CA 91367  
[Studentinsuranceusa.com](https://www.studentinsuranceusa.com)



## 2025 – 2026 STUDENT ACCIDENT INSURANCE COVERAGE

**OPTIONAL SCHOOL TIME ACCIDENT COVERAGE** - Insurance coverage is provided for covered Injuries incurred during the hours and days when school is in session and while attending or participating in school sponsored and supervised activities on or off school premises. Includes participation in: Summer Recreation Activities sponsored by the school; One-Day School Field Trips (no Overnight) and School Sponsored Religious Activities. Coverage is provided for traveling to, during or after such activities as a member of a group in transportation furnished or arranged by the Policyholder and traveling directly to or from their home premises and the school or the site of a covered activity. No coverage is provided while participating in Interscholastic Sports.  
**Annual Premium: Plan “Low” – \$10.00 Plan “Medium” – \$16.00 Plan “High” – \$25.00**

**OPTIONAL 24-HOUR ACCIDENT COVERAGE** - Insurance coverage is provided around the clock, 24 Hours per day. Provides coverage during the weekends and vacation periods including the entire summer. Students are protected while at Home or away, any place, any time, anywhere. No coverage is provided while participating in Interscholastic Sports.  
**Annual Premium: Plan “Low” – \$48.00 Plan “Medium” – \$65.00 Plan “High” – \$125.00**

**OPTIONAL 24-HOUR DENTAL COVERAGE (Can be purchased separately or with other coverage)** – Insurance coverage is in effect 24 Hours a day. Injury must be treated within 60 days after the Accident occurs. Benefits are payable within 12 months after the date of Injury. The maximum eligible expenses payable per covered Injury is \$25,000. In addition, when the dentist certifies that treatment must be deferred until after the Benefit Period, deferred benefits will be paid to a maximum of \$1,000. The Student must be treated by a legally qualified dentist who is not a member of the student’s Immediate Family for Injury to teeth. Coverage is limited to treatment of sound, natural teeth.  
**Annual Premium: \$8.00**

**COVERAGE PERIOD** – Coverage under the Optional School-Time Accident Coverage, the Optional 24-Hour Accident Coverage and the Optional 24-Hour Dental Coverage starts on the date of premium receipt but not before the start of the school year. Optional School-Time Accident Coverage ends at the close of the regular nine-month school term, except while the student is attending academic classroom sessions exclusively sponsored and solely supervised by the School during the summer. Optional 24-Hour Accident and Dental Coverage ends when school reopens for the following school year. Coverage is available under the plan throughout the school year at the premiums quoted (**no pro rata premiums available**).

<b>SCHEDULE OF BENEFITS</b>			
Coverage for Injuries due to Accidents only			
<b>Maximum Benefit:</b>	<b>Plan “Low”</b>	<b>Plan “Medium”</b>	<b>Plan “High”</b>
School-Time Option	\$25,000	\$50,000	\$100,000
24-Hour Option	\$25,000	\$50,000	\$100,000
Injuries Involving Motor Vehicles	\$10,000	\$10,000	\$ 10,000
Death Benefit/Double Dismemberment	\$10,000	\$20,000	\$ 20,000
Single Dismemberment	\$ 5,000	\$10,000	\$ 10,000
<b>Loss Period for Medical Benefits</b>	Treatment must begin within 60 days from the date of Injury		
<b>Benefit Period for Medical and AD&amp;D/Loss of Sight Benefits</b>	1 Year	1 Year	1 Year
<b>Excess Coverage Applicability</b>	Full Excess	Full Excess	Full Excess
<b>Hospital/Facility Services - Inpatient</b>			
Hospital Room and Board (Semi-Private Room Rate)	65% RE*	75% RE*	80% RE*
Inpatient Hospital Miscellaneous	65% RE*	75% RE*	80% RE*
<b>Hospital/Facility Services - Outpatient</b>			
Free-Standing Ambulatory Surgical Facility	65% RE* to \$500 Maximum	75% RE* to \$800 Maximum	80% RE* to \$1,500 Maximum
Outpatient Hospital Miscellaneous (Except physician services and x-rays paid as below)	65% RE* to \$500 Maximum	75% RE* to \$800 Maximum	80% RE* to \$1,500 Maximum
Hospital Emergency Room	65% RE* to \$500 Maximum	75% RE* to \$800 Maximum	80% RE* to \$1,500 Maximum
<b>Physician's Services</b>			
Surgical	65% RE*	75% RE*	80% RE*
Assistant Surgeon	25% of Surgical Benefits	25% of Surgical Benefits	25% of Surgical Benefits
Anesthesiologist	25% of Surgical Benefits	25% of Surgical Benefits	25% of Surgical Benefits
Physician's Outpatient Treatment in connection with Physical Therapy and/or Spinal Manipulation	65% RE* / \$25 Visit/5 Visit Max.	75% RE* / \$30 Visit/7 Visit Max.	80% RE* / \$40 Visit/8 Visit Max.
Physician's Non-surgical Treatment (Except as above)	65% RE*	75% RE*	80% RE*
<b>Other Services</b>			
Registered Nurses' Services	65% RE*	75% RE*	80% RE*
Prescriptions - outpatient	65% RE*	75% RE*	80% RE*
Laboratory Tests – Outpatient	65% RE*	75% RE*	80% RE*
X-rays, includes interpretation – Outpatient	65% RE*	75% RE*	80% RE*
Diagnostic Imaging (MRI, CAT Scan, etc) includes interpretation	65% RE*	75% RE*	80% RE*
Ground Ambulance	65% RE*	75% RE*	80% RE*
Durable Medical Equipment (includes Orthopedic Braces & Appliances)	65% RE*	75% RE*	80% RE*
Dental Treatment to sound, natural teeth due to covered injury	65% RE* to \$500 Maximum	75% RE* to \$800 Maximum	80% RE* to \$1,500 Maximum
Replacement of eyeglasses, hearing aids, contact lenses, if medical treatment is also received for the covered injury.	\$150 Maximum	\$500 Maximum	\$700 Maximum
<b>*RE means Reasonable Expense</b>			<b>GER_0418 ENOSPORTS(0009)</b>

### 2025 – 2026 ENROLLMENT APPLICATION (please print or type)

Student's Last Name \_\_\_\_\_ Student's First Name \_\_\_\_\_ Student's Middle Initial \_\_\_\_\_ Grade \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Telephone Number \_\_\_\_\_ Birthdate \_\_\_\_\_  
 School System \_\_\_\_\_ Name of School \_\_\_\_\_

Check your selection:    Plan “Low”             School-Time \$10.00     24-Hour Accident \$ 48.00     24-Hour Dental \$8.00  
                                  Plan “Medium”         School-Time \$16.00     24-Hour Accident \$ 65.00     24-Hour Dental \$8.00  
                                  Plan “High”             School-Time \$25.00     24-Hour Accident \$125.00     24-Hour Dental \$8.00

**Please make check payable to Gerber Life Insurance Company**

Total Enclosed: \_\_\_\_\_

Signature of Parent or Guardian \_\_\_\_\_ Date \_\_\_\_\_

**EXCESS COVERAGE PROVISION** The Company will pay Reasonable Expenses that are not recoverable from any Other Plan. The Company will determine the amount of benefits provided by Other Plans without reference to any coordination of benefits, non-duplication of benefits, or similar provisions. The amount from Other Plans includes any amount, to which the Insured is entitled, whether or not a claim is made for the benefits. This Blanket Student Accident Insurance is secondary to all other policies. This provision will not apply if the total Reasonable Expenses incurred for Hospital and Professional Services Benefits are less than the amount stated in the Schedule of Benefits under Excess Coverage Applicability.

**MEDICAL BENEFITS** When a covered Injury to a student results in 1) treatment by a legally qualified Physician or surgeon (other than a member of the immediate family or person retained by the school) or 2) Hospital confinement, and treatment begins within 60 days from the date of Injury, the Company will pay the benefit as shown in the Schedule of Benefits, subject to the Excess Coverage Provision above. Only eligible medical expenses incurred by the Insured within 52 weeks from the date of the Accident are covered. Benefits for any one Accident shall not exceed in the aggregate the maximum stated in the Medical Benefit plan purchased. Expenses incurred after one year from the date of Injury are not covered, even though the service is a continuing one, or one that is necessarily delayed beyond one year from the date of Injury.

**ACCIDENTAL DEATH, DISMEMBERMENT AND LOSS OF SIGHT** When a covered Injury results in any of the Losses to the Insured which are stated in the Schedule of Benefits for Accidental Death, Dismemberment, or Loss of Sight then the Company will pay the benefit stated in the schedule for that Loss. The Loss must be sustained within 365 days after the date of the Accident.

The maximum benefit payable under this provision is stated in the Schedule of Benefits under Maximums and Benefit Period: 1) Life 2) Both Hands or Both Feet or Sight of Both Eyes; 3) Loss of One Hand and One Foot; 4) Loss of One Hand and Entire Sight of One Eye; 5) Loss of One Foot and Entire Sight of One Eye; 6) Loss of One Hand or Foot; 7) Loss of Sight in One Eye; 8) Loss of Thumb and Index Finger of the Same Hand. Half of the maximum benefit will be paid for the Loss of one Hand, one Foot or the Sight of one eye. Loss of Hand or Foot means the complete Severance through or above the wrist or ankle joint. Loss of Sight means the total, permanent Loss of Sight in One Eye. The Loss of Sight must be irrecoverable by natural, surgical or artificial means. Loss of Thumb and Index Finger of the Same Hand means complete Severance through or above the metacarpophalangeal joints of the same hand (the joints between the fingers and the hand). Severance means the complete separation and dismemberment of the part from the body. If the Insured suffers more than one of the above covered losses as a result of the same Accident the total amount the Company will pay is the maximum benefit. Benefits paid under this provision will be paid in addition to any other benefits provided by the Policy. Benefits under this provision are subject to all other provisions of the Policy, including all Coverage and Limitations, Maximums and Exclusions.

**DEFINITIONS** **Injury** means bodily injury caused by an Accident. The Injury must occur while the Policy is in force and while the Insured is covered under the Policy. The Injury must be sustained as stated on the face page of the Policy, except where specifically stated otherwise in the Policy. **Accident** means a sudden, unexpected and unforeseen, identifiable event producing at the time objective symptoms of an Injury. The Accident must occur while the Insured is covered under the Policy. **Other Plan** means any other valid and collectible insurance or self-funded plan such as: individual and family type insurance coverage; group, blanket or franchise insurance, group hospital, medical service, pre-payment, trustee, Union Welfare; Blue-Cross, Blue Shield, group practice or other pre-payment coverage; labor-management plans, or employee benefit organization plans; self-funded ERISA plan, Workers' Compensation Law, Occupational Disease Law or any similar legislation; Medicare; or "No-Fault" auto legislation, where applicable. **Reasonable Expense** means the average amount charged by most providers for treatment, service or supplies in the geographic area where the treatment, service or supply is provided. Such services and supplies must be recommended and approved by a Physician.

**EXCLUSIONS** No Benefits are payable for Hospital and Professional Services for the following: 1) Injuries which are not caused by an Accident; 2) Treatment for hernia, regardless of cause, Osgood Schlatter's disease, or osteochondritis; 3) Injury sustained as a result of operating, riding in or upon, or alighting from a two-, three-, or four-wheeled recreational motor vehicle or snowmobile; 4) Aggravation, during a Regularly Scheduled Activity, of an Injury the Insured suffered before participating in that Regularly Scheduled Activity, unless the Company receives a written medical release from the Insured's Physician; 5) Injury sustained as a result of practice or play in interscholastic tackle football and/or sports, unless the premium required under the Football and/or Sports Coverage provision has been paid; 6) Any expense for which benefits are payable under a Catastrophic Accident Insurance Program of the State Interscholastic Activities Association; 7) Treatment performed by a member of the Insured's Immediate Family or by a person retained by the School; 8) Injury caused by war or acts of war; suicide or intentionally self-inflicted Injury, while sane or insane; violating or attempting to violate the law; the taking part in any illegal occupation; fighting or brawling except in self defense; being legally intoxicated or under the influence of alcohol as defined by the laws of the state in which the Injury occurs; or being under the influence of any drugs or narcotic unless administered by or on the advice of a Physician; 9) Medical expenses for which the Insured is entitled to benefits under any (a) Workers' Compensation act; or (b) mandatory no-fault automobile insurance contract; or similar legislation; 10) Expense incurred for treatment of temporomandibular joint dysfunction and associated myofascial pain; and 11) Expenses incurred for experimental or investigational treatment or procedures.

#### RETAIN THIS DESCRIPTION FOR YOUR RECORDS

This is not a Policy, rather a brief description of the benefits provided under the master policy issued to the school. Please refer to the master policy for further details. **IMPORTANT NOTICE – THIS POLICY DOES NOT PROVIDE COVERAGE FOR SICKNESS. This brochure has been designed to illustrate the highlights of this insurance. All information in this brochure is subject to the provisions of Policy Form COL-11(CA), underwritten by Gerber Life Insurance Company (the Company). If there is any conflict between this brochure and the Policy, the Policy will prevail. Please see the Master Policy for individual state details.**

#### HOW TO FILE A CLAIM

Written notice of claim must be given to the Company within 90 days after the occurrence or commencement of any loss covered by this policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the Named Insured to the Company, with information sufficient to identify the Named Insured shall be deemed notice to the Company. Written proof of loss must be furnished to the Company at its said office within 90 days after the date of such loss.

In the event of an Accident, students should: 1) Secure treatment at the nearest medical facility of their choice; 2) If you have other insurance, submit your claim to your other insurer. When you receive the explanation of benefits notice from your primary carrier, send it to us; 3) Obtain a receipt (if payment of any bills were made) and itemized copy of charges from the provider of medical services and send copies of their itemized bills and the fully completed and signed accident claim form to the claims office – mail all correspondence to WEB-TPA, P.O. Box 2415, Grapevine, TX 76099-2415; and 3) **Call 1-866-975-9468** with any Claims questions.

**UNDERWRITTEN BY:**  
Gerber Life Insurance Company  
White Plains, NY 10605

**MARKETING AGENT:**  
Student Insurance  
6320 Canoga Ave, 12<sup>th</sup> Floor  
Woodland Hills, CA 91367  
(310) 826-5688

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**To apply for coverage, please enroll on-line with a credit card at [www.k12specialmarkets.com](http://www.k12specialmarkets.com) or cut along the dotted line, complete the form and mail it, along with your check or money order, to the Please Return To: address shown below.**

Please Return To: Student Insurance  
c/o K12Special Markets Plan Administrators  
1055 Main Street, Suite 101  
Stevens Point, WI 54481

**PLEASE READ THIS INFORMATION CAREFULLY. It is important.**

**PLEASE FOLLOW THESE INSTRUCTIONS TO FILE A CLAIM**

**ALL INFORMATION MUST BE PROVIDED IN ORDER FOR CLAIM TO BE PROCESSED. PROCESSING OF YOUR CLAIM WILL BE DELAYED IF COMPLETE INFORMATION IS NOT RECEIVED**

**NOTE: The accident policy benefits are limited and may not provide 100% coverage. Accident medical expense coverage under this policy is provided on an Excess Basis, and in most instances, benefits will only be paid under this plan after your own personal or group insurance has paid out its benefits. Completion of a claim form does not guarantee benefit payment. Each claim is reviewed according to the policy provisions.**

**Claim Guidelines: The following guidelines must be followed.**

◆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. When you receive the explanation of benefits (sample attached) notice from your primary carrier, send it to us along with the corresponding HCFA/UB04 medical bills and with the fully completed claim form. You must submit the provider's medical bills; balance due statements will not be processed. Medical bills must include the procedure & diagnosis code along with the Provider's federal identification number. These bills are:

- 1) HCFA-1500 (standard form used by Providers; sample attached)
- 2) UB-04 or UB-92 (standard form used by Hospitals sample attached)
- 3) ADA Dental Claim Form and a letter from the dentist verifying the injured tooth was whole, sound and natural. (All dental bills must be submitted through your primary insurance's medical and dental plans first before submitting the bills to WebTPA)

It would be helpful if the following was given to all providers the injured person is seeking treatment from:

1. WebTPA contact information
2. Organization/School name found on the claim form
3. Policy number found on the claim form

This way the providers of service can work directly with the claim office and provide them with the correct billing forms (itemized bill to include procedure & diagnosis code and tax id number) needed to process a claim.

◆If you already paid the medical bill, include a paid receipt or a copy of your cancelled check at the same time you submit the medical bill. Otherwise payment will be made to the providers of service (Hospital, Physician or Others).

◆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. File claim electronically by clicking [here](#).

◆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, MEDICAL BILLS, AND CORRESPONDENCE FOR YOUR OWN RECORDS UNTIL YOUR CLAIM HAS BEEN PROCESSED.**

# SAMPLE HCFA 1500

PLEASE DO NOT STAPLE IN THIS AREA

HEALTH INSURANCE CLAIM FORM

1 MEDICARE MEDICAID CHARLES CHARIPUR GROUP HEALTH PLAN OTHER INSURER'S ID NUMBER (FROM PROGRAM IN ITEM 1)

2 PATIENT'S NAME (LAST FIRST MIDDLE INITIAL) (SURNAME) 3 BIRTH DATE MM DD YY 4 INSURER'S NAME (SEE INSTRUCTIONS) 5 PATIENT'S ADDRESS (SEE INSTRUCTIONS) 6 PATIENT'S RELATIONSHIP TO INSURED 7 INSURER'S ADDRESS (SEE INSTRUCTIONS) 8 OTHER INSURER'S POLICY OR GROUP NUMBER 9 OTHER INSURER'S DATE OF BIRTH 10 EMPLOYER'S NAME OR SCHOOL NAME 11 INSURANCE PLAN NAME OR PROGRAM NAME 12 EMPLOYER'S NAME OR SCHOOL NAME 13 INSURANCE PLAN NAME OR PROGRAM NAME 14 EMPLOYER'S NAME OR SCHOOL NAME 15 INSURANCE PLAN NAME OR PROGRAM NAME 16 EMPLOYER'S NAME OR SCHOOL NAME 17 INSURANCE PLAN NAME OR PROGRAM NAME 18 EMPLOYER'S NAME OR SCHOOL NAME 19 INSURANCE PLAN NAME OR PROGRAM NAME 20 EMPLOYER'S NAME OR SCHOOL NAME 21 INSURANCE PLAN NAME OR PROGRAM NAME 22 EMPLOYER'S NAME OR SCHOOL NAME 23 INSURANCE PLAN NAME OR PROGRAM NAME 24 EMPLOYER'S NAME OR SCHOOL NAME 25 INSURANCE PLAN NAME OR PROGRAM NAME 26 EMPLOYER'S NAME OR SCHOOL NAME 27 INSURANCE PLAN NAME OR PROGRAM NAME 28 EMPLOYER'S NAME OR SCHOOL NAME 29 INSURANCE PLAN NAME OR PROGRAM NAME 30 EMPLOYER'S NAME OR SCHOOL NAME 31 INSURANCE PLAN NAME OR PROGRAM NAME 32 EMPLOYER'S NAME OR SCHOOL NAME 33 INSURANCE PLAN NAME OR PROGRAM NAME 34 EMPLOYER'S NAME OR SCHOOL NAME 35 INSURANCE PLAN NAME OR PROGRAM NAME 36 EMPLOYER'S NAME OR SCHOOL NAME 37 INSURANCE PLAN NAME OR PROGRAM NAME 38 EMPLOYER'S NAME OR SCHOOL NAME 39 INSURANCE PLAN NAME OR PROGRAM NAME 40 EMPLOYER'S NAME OR SCHOOL NAME 41 INSURANCE PLAN NAME OR PROGRAM NAME 42 EMPLOYER'S NAME OR SCHOOL NAME 43 INSURANCE PLAN NAME OR PROGRAM NAME 44 EMPLOYER'S NAME OR SCHOOL NAME 45 INSURANCE PLAN NAME OR PROGRAM NAME 46 EMPLOYER'S NAME OR SCHOOL NAME 47 INSURANCE PLAN NAME OR PROGRAM NAME 48 EMPLOYER'S NAME OR SCHOOL NAME 49 INSURANCE PLAN NAME OR PROGRAM NAME 50 EMPLOYER'S NAME OR SCHOOL NAME 51 INSURANCE PLAN NAME OR PROGRAM NAME 52 EMPLOYER'S NAME OR SCHOOL NAME 53 INSURANCE PLAN NAME OR PROGRAM NAME 54 EMPLOYER'S NAME OR SCHOOL NAME 55 INSURANCE PLAN NAME OR PROGRAM NAME 56 EMPLOYER'S NAME OR SCHOOL NAME 57 INSURANCE PLAN NAME OR PROGRAM NAME 58 EMPLOYER'S NAME OR SCHOOL NAME 59 INSURANCE PLAN NAME OR PROGRAM NAME 60 EMPLOYER'S NAME OR SCHOOL NAME 61 INSURANCE PLAN NAME OR PROGRAM NAME 62 EMPLOYER'S NAME OR SCHOOL NAME 63 INSURANCE PLAN NAME OR PROGRAM NAME 64 EMPLOYER'S NAME OR SCHOOL NAME 65 INSURANCE PLAN NAME OR PROGRAM NAME 66 EMPLOYER'S NAME OR SCHOOL NAME 67 INSURANCE PLAN NAME OR PROGRAM NAME 68 EMPLOYER'S NAME OR SCHOOL NAME 69 INSURANCE PLAN NAME OR PROGRAM NAME 70 EMPLOYER'S NAME OR SCHOOL NAME 71 INSURANCE PLAN NAME OR PROGRAM NAME 72 EMPLOYER'S NAME OR SCHOOL NAME 73 INSURANCE PLAN NAME OR PROGRAM NAME 74 EMPLOYER'S NAME OR SCHOOL NAME 75 INSURANCE PLAN NAME OR PROGRAM NAME 76 EMPLOYER'S NAME OR SCHOOL NAME 77 INSURANCE PLAN NAME OR PROGRAM NAME 78 EMPLOYER'S NAME OR SCHOOL NAME 79 INSURANCE PLAN NAME OR PROGRAM NAME 80 EMPLOYER'S NAME OR SCHOOL NAME 81 INSURANCE PLAN NAME OR PROGRAM NAME 82 EMPLOYER'S NAME OR SCHOOL NAME 83 INSURANCE PLAN NAME OR PROGRAM NAME 84 EMPLOYER'S NAME OR SCHOOL NAME 85 INSURANCE PLAN NAME OR PROGRAM NAME 86 EMPLOYER'S NAME OR SCHOOL NAME 87 INSURANCE PLAN NAME OR PROGRAM NAME 88 EMPLOYER'S NAME OR SCHOOL NAME 89 INSURANCE PLAN NAME OR PROGRAM NAME 90 EMPLOYER'S NAME OR SCHOOL NAME 91 INSURANCE PLAN NAME OR PROGRAM NAME 92 EMPLOYER'S NAME OR SCHOOL NAME 93 INSURANCE PLAN NAME OR PROGRAM NAME 94 EMPLOYER'S NAME OR SCHOOL NAME 95 INSURANCE PLAN NAME OR PROGRAM NAME 96 EMPLOYER'S NAME OR SCHOOL NAME 97 INSURANCE PLAN NAME OR PROGRAM NAME 98 EMPLOYER'S NAME OR SCHOOL NAME 99 INSURANCE PLAN NAME OR PROGRAM NAME 100 EMPLOYER'S NAME OR SCHOOL NAME

# SAMPLE UB-04

UB-04

1 PATIENT NAME 2 PATIENT ADDRESS 3 PATIENT CITY 4 PATIENT STATE 5 PATIENT ZIP 6 PATIENT PHONE 7 PATIENT FAX 8 PATIENT EMAIL 9 PATIENT FAX 10 PATIENT FAX 11 PATIENT FAX 12 PATIENT FAX 13 PATIENT FAX 14 PATIENT FAX 15 PATIENT FAX 16 PATIENT FAX 17 PATIENT FAX 18 PATIENT FAX 19 PATIENT FAX 20 PATIENT FAX 21 PATIENT FAX 22 PATIENT FAX 23 PATIENT FAX 24 PATIENT FAX 25 PATIENT FAX 26 PATIENT FAX 27 PATIENT FAX 28 PATIENT FAX 29 PATIENT FAX 30 PATIENT FAX 31 PATIENT FAX 32 PATIENT FAX 33 PATIENT FAX 34 PATIENT FAX 35 PATIENT FAX 36 PATIENT FAX 37 PATIENT FAX 38 PATIENT FAX 39 PATIENT FAX 40 PATIENT FAX 41 PATIENT FAX 42 PATIENT FAX 43 PATIENT FAX 44 PATIENT FAX 45 PATIENT FAX 46 PATIENT FAX 47 PATIENT FAX 48 PATIENT FAX 49 PATIENT FAX 50 PATIENT FAX 51 PATIENT FAX 52 PATIENT FAX 53 PATIENT FAX 54 PATIENT FAX 55 PATIENT FAX 56 PATIENT FAX 57 PATIENT FAX 58 PATIENT FAX 59 PATIENT FAX 60 PATIENT FAX 61 PATIENT FAX 62 PATIENT FAX 63 PATIENT FAX 64 PATIENT FAX 65 PATIENT FAX 66 PATIENT FAX 67 PATIENT FAX 68 PATIENT FAX 69 PATIENT FAX 70 PATIENT FAX 71 PATIENT FAX 72 PATIENT FAX 73 PATIENT FAX 74 PATIENT FAX 75 PATIENT FAX 76 PATIENT FAX 77 PATIENT FAX 78 PATIENT FAX 79 PATIENT FAX 80 PATIENT FAX 81 PATIENT FAX 82 PATIENT FAX 83 PATIENT FAX 84 PATIENT FAX 85 PATIENT FAX 86 PATIENT FAX 87 PATIENT FAX 88 PATIENT FAX 89 PATIENT FAX 90 PATIENT FAX 91 PATIENT FAX 92 PATIENT FAX 93 PATIENT FAX 94 PATIENT FAX 95 PATIENT FAX 96 PATIENT FAX 97 PATIENT FAX 98 PATIENT FAX 99 PATIENT FAX 100 PATIENT FAX

# SAMPLE ADA DENTAL CLAIM FORM

American Dental Association Dental Claim Form

1 Type of Transaction (Mark all applicable boxes) 2 Preauthorization/Prescription Number 3 Insurance Company/Dental Benefit Plan Information 4 Other Coverage 5 Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix) 6 Date of Birth (MM/DD/YYYY) 7 Gender 8 Policyholder/Subscriber ID (SIN or ID#) 9 Plan/Group Number 10 Patient's Relationship to Person Named in #5 11 Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code 12 Name and Address of Facility Where Services Were Rendered (If other than home or office) 13 Date of Birth (MM/DD/YYYY) 14 Gender 15 Policyholder/Subscriber ID (SIN or ID#) 16 Plan/Group Number 17 Employee Name 18 Relationship to Policyholder/Subscriber in #12 Above 19 Student Status 20 Name (Last, First, Middle Initial, Suffix, Address, City, State, Zip Code) 21 Date of Birth (MM/DD/YYYY) 22 Gender 23 Patient ID/Account # (Assigned by Dentist) 24 Procedure Code 25 Tooth Number 26 Procedure Code 27 Description 28 Fee 29 Remarks 30 Ancillary Claim/Treatment Information 31 Billing Dentist or Dental Entity 32 Patient Name 33 Address 34 City 35 State 36 ZIP 37 Date of Birth (MM/DD/YYYY) 38 Gender 39 License Number 40 License State 41 License Number 42 License State 43 License Number 44 License State 45 License Number 46 License State 47 License Number 48 License State 49 License Number 50 License State 51 License Number 52 License State 53 License Number 54 License State 55 License Number 56 License State 57 License Number 58 License State 59 License Number 60 License State 61 License Number 62 License State 63 License Number 64 License State 65 License Number 66 License State 67 License Number 68 License State 69 License Number 70 License State 71 License Number 72 License State 73 License Number 74 License State 75 License Number 76 License State 77 License Number 78 License State 79 License Number 80 License State 81 License Number 82 License State 83 License Number 84 License State 85 License Number 86 License State 87 License Number 88 License State 89 License Number 90 License State 91 License Number 92 License State 93 License Number 94 License State 95 License Number 96 License State 97 License Number 98 License State 99 License Number 100 License State

# SAMPLE EOB (EXPLANATION OF BENEFITS)

UNITEDHEALTHCARE SERVICE LLC  
GREENSBORO SERVICE CENTER  
P O BOX 740800  
ATLANTA GA 30374-0800  
PHONE: 1-800-838-8010  
VISIT WWW.MYUHC.COM FOR SELF SERVICE

UnitedHealthcare  
A UnitedHealth Group Company

PAGE: 1 of 1  
DATE: 04/29/18  
SSN/ID #:   
EMPLOYEE:   
CONTRACT:   
BENEFIT PLAN: PFIZER INC

EXPLANATION OF BENEFITS

1 2 3 4 5 6 7 8

PATIENT/RELAT CLAIM NUMBER	PROVIDER/SERVICE	DATE OF SERVICE	AMOUNT CHARGED	NOT COVERED	AMOUNT ALLOWED	COPY/ DEDUCTIBLE	PLAN COVERS	BENEFIT AVAILABLE	REMARK CODE
9061512101	MEDICAL SERVICES	09/19/10	379.00	297.83	81.17		80%	64.94*	4C
	TOTAL		379.00	297.83	81.17			64.94	
								44.64	
								20.30	

(\*) INDICATES PAYMENT ASSIGNED TO PROVIDER

REMARK CODE(S) LISTED BELOW ARE REFERENCED IN THE "SERVICE DETAIL" SECTION UNDER THE HEADING "REMARK CODE"  
(4C) THIS PLAN DETERMINES BENEFITS ONCE MEDICARE MAKES PAYMENT. IF MEDICARE PAYS LESS THAN THIS PLAN'S BENEFIT, THIS PLAN WILL CONSIDER THE DIFFERENCE. THIS PLAN'S ALLOWABLE BENEFITS ARE BASED ON THE MEDICARE APPROVED AMOUNT IF THE PHYSICIAN OR PROVIDER ACCEPTED MEDICARE'S ASSIGNMENT OR ON THE LIMITING CHARGE IF THEY DID NOT ACCEPT THE ASSIGNMENT. THE PATIENT IS RESPONSIBLE FOR THE DIFFERENCE BETWEEN THE ALLOWABLE AMOUNT AND THE TOTAL AMOUNT PAID BY BOTH PLANS. THE PATIENT MUST PAY ANY APPLICABLE PLAN DEDUCTIBLES AND CO-PAYS BEFORE THIS PLAN CAN PAY ANY BENEFITS.

11 BENEFIT PLAN PAYMENT SUMMARY INFORMATION: \$20.30

SATISFIED 2010 TO-DATE	DEDUCTIBLE	OUT OF POCKET
FAMILY \$5	\$1000.00	\$1328.77
INDV	\$500.00	\$1281.45
PLAN YEAR 2018	FAMILY \$1000.00	FAMILY \$4000.00
	INDV \$500.00	INDV \$4000.00

9 10 11 12 13



CLAIM FORM
SIGNED CLAIM FORM IS REQUIRED

- 1. PLEASE FULLY COMPLETE THIS FORM PAGE 1 & PAGE 2
2. ATTACH HCFA/UB04-MEDICAL BILLS & EOBS FROM ANY OTHER INSURANCE YOU HAVE
3. SEND ALL CORRESPONDENCE TO:

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

Toll-Free: 866-975-9468
Fax: 469-417-1969
Email: benefit.assist@webtpa.com
File Electronically: Click Here

IMPORTANT NOTICE:
This plan of insurance is secondary, in most instances, to any health insurance you have. If you have other insurance, submit your claim (health and/or dental) to your other insurer. When you receive their Benefit Statement, send it to us along with your HCFA/UB04 (medical bills) and this completed form. 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/College Name Policy Number
School/Team/League Name Phone No. ( )
Address Email
Type of Activity/Sport

If Athletics, designate P.E. Class Intramural Interscholastic Intercollegiate Game Jr. Varsity Varsity
Youth Adult Practice Other

Name of injured person/student

Date of Accident Accident Time

Date of First Treatment Has treatment been completed? Yes No

Where and how did accident occur? (Please be specific)

Part of body Injured Right or Left 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

Injured Party/Student Legal Name Preferred/Nickname:

Date of Birth Age Grade Level Male Female

Claimant is a Student Player Coach Official/Umpire Volunteer Child Care Participant CE Student (# of credits)

Address of Injured Person or Parents/Guardian

Phone No. ( ) Email Address

If Injured party is over age 18: Employer Name and Address

Phone No. ( ) Self Employed Unemployed

Father/Guardian Name

Employer Name and Address Phone No. ( )

Self Employed Unemployed

PLEASE CONTINUE TO THE NEXT PAGE OF THE FORM WHICH MUST BE COMPLETED IN FULL

Mother/Guardian Name \_\_\_\_\_

Employer Name and Address \_\_\_\_\_ Phone No. (     ) \_\_\_\_\_

Self Employed     Unemployed

If Dental Injury: Please submit verification from the dentist that the tooth/teeth are whole, sound and natural.

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

Name of all companies providing claimant insurance coverage or prepaid health plans

**Name of Company**

**Address**

**Policy #**

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:** Injured Person, 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:** Injured Person, Parent or Guardian \_\_\_\_\_ Date: \_\_\_\_\_