P.O. Box 117558
Carrollton, Texas 75011-7558
Phone: (972) 512-5600 Fax: (972) 512-5818
Toll Free (866) 409-5734
E-mail : K12claims@hsri.com

School District: ____________________

School Name: ____________________

Student ID #: ____________________

Policy Number: ____________________

STUDENT CLAIM FORM

1. Please fully complete this form
2. Attach itemized bills
3. Mail, E-mail or Fax to *HSR*

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
☐ Not school related
☐ P.E. class
☐ During lunch hour
☐ In school bus
☐ School sponsored field trip
☐ Traveling to/from school
☐ Athletic period
☐ On school property during school hours
☐ School sponsored activity during school hours
☐ 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: X Date:	Signature of School Official: 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 ____________________

IF OTHER INSURANCE OR HEALTH CARE PLANS EXIST, PLEASE SUBMIT COPIES of their EXPLANATION OF BENEFITS along with your claim.
IF NO OTHER INSURANCE or HEALTH PLAN EXISTS, PLEASE READ & SIGN BELOW.
I agree that should it be determined at a later date there is insurance (or similar), to reimburse *HEALTH SPECIAL RISK, INC.*, or the insurance company to the extent of any amount collectible.

Signature of Parent/Legal Guardian: X Date:	Signature of Witness: X Date:

PART III – 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 ____________________

I hereby authorize any insurance company, hospital, physician or other person who has attended or examined 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. A photo static copy of this authorization shall be considered as effective and valid as the original.

SIGNATURE ____________________ DATE ____________________

By entering your name above in Part II and Part III, 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.

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 of 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 and amount) incurred (including the CPT/procedure code).
4. If this information is not on the bill when you send this in we will have to contact the doctor/hospital which will delay the review of your claim. "Balance Due" or "Balance Forward" statements do not contain sufficient information to complete your claim.

EXCESS INSURANCE

1. This policy provides coverage on a secondary/excess basis. If 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 other, 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. thru 6:00 p.m. central time, Monday – Friday. You may also forward any documents by fax to (972) 512-5818.

Health Special Risk, Inc.
P.O. Box 117558
Carrollton, TX 75011-7558