

**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 benefits will only be paid under this plan after your own personal or group insurance has paid out its benefits. The maximum benefit for physician's outpatient treatment in connection with physical therapy and/or spinal manipulation is \$1,000 per non-surgical injury for coverage purchased by the school. Completion of a claim form does not guarantee benefit payment. Each claim is reviewed according to the policy provisions.

**Claim Guidelines: The following claim 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 (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. 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.

◆ 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.**

PLEASE DO NOT STAPLE IN THIS AREA

APPROVED OVERSICOR BOX

HEALTH INSURANCE CLAIM FORM

1 MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN (GHP) OTHER 10 INSURED'S ID NUMBER (FORM PROGRAM NUMBER)

2 PATIENT'S NAME (Last, First, Middle Initial) 3 PATIENT'S BIRTH DATE MM / DD / YY 4 INSURED'S NAME (Last, First, Middle Initial)

5 PATIENT'S ADDRESS (No. & Street) 6 PATIENT'S RELATIONSHIP TO INSURED (Self, Spouse, Child, Other) 7 INSURED'S ADDRESS (No. & Street)

8 PATIENT'S STATUS (Single, Married, Other) 9 CITY 10 STATE 11 ZIP CODE 12 TELEPHONE (Include Area Code)

13 OTHER INSURED'S NAME (Last, First, Middle Initial) 14 EMPLOYMENT EQUIPMENT OR PREVIOUS 15 INSURED'S DATE OF BIRTH MM / DD / YY 16 SEX M F

17 OTHER INSURED'S DATE OF BIRTH MM / DD / YY 18 ALSO ACCIDENT? YES NO 19 PLACE (Home, Other) 20 EMPLOYMENT NAME OR SCHOOL NAME

21 EMPLOYER'S NAME OR SCHOOL NAME 22 INSURANCE PLAN NAME OR PROGRAM NAME 23 IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO (If Yes, when did you complete form 1500)

24 INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (Include address and telephone number) 25 DATE SIGNED

26 DATE EMPLOYMENT TERMINATED (MM / DD / YY) 27 DATE EMPLOYMENT BEGAN (MM / DD / YY) 28 DATE EMPLOYMENT BEGAN (MM / DD / YY)

29 OUTPATIENT LUMP SUM AMOUNT (MM / DD / YY) 30 OUTPATIENT LUMP SUM AMOUNT (MM / DD / YY)

31 MEDICARE REASSIGNMENT CODE ORIGINAL ASP NO 32 PRIOR AUTHORIZATION NUMBER

33 SIGNATURE OF PHYSICIAN OR SUPPLIER (Include address and telephone number) 34 DATE SIGNED 35 NAME AND ADDRESS OF FACILITY (where services were rendered, if other than home or office)

36 FEDERAL TAX ID NUMBER 37 PATIENT ACCOUNT NO 38 ACCOUNT ASSIGNMENT (YES NO) 39 TOTAL CHARGE \$ 40 AMOUNT PAID \$ 41 BALANCE DUE \$

32 CHARGES (DATE OF SERVICE, ICD-9 CODE, PROCEDURE, SERVICE, OR SUPPLIER, CHARGES CODE, S, CHARGES, DAYS, UNITS, RATE, PLAN, COB, RESERVED FOR LOCAL USE)

FORM HCFA 1500 (12-00) FORM 986-100 FORM OVER 1002

UB-04

1 PATIENT NAME 2 STREET ADDRESS 3 CITY 4 STATE 5 ZIP CODE

6 PATIENT ID NUMBER 7 PATIENT DATE OF BIRTH 8 PATIENT SEX 9 PATIENT RACE

10 PATIENT RELATIONSHIP TO INSURED 11 INSURED NAME 12 INSURED DATE OF BIRTH 13 INSURED SEX

14 INSURED RELATIONSHIP TO PATIENT 15 EMPLOYER NAME 16 EMPLOYER ADDRESS 17 EMPLOYER CITY 18 EMPLOYER STATE 19 EMPLOYER ZIP CODE

20 DATE OF SERVICE 21 ICD-9-CM PROCEDURE CODE 22 ICD-9-CM DIAGNOSIS CODE 23 ICD-9-CM DRUG CODE 24 ICD-9-CM SUPPLY CODE

25 CHARGE CODE 26 CHARGE DESCRIPTION 27 CHARGE AMOUNT 28 CHARGE UNIT 29 CHARGE RATE 30 CHARGE PLAN 31 CHARGE COB 32 CHARGE RESERVED FOR LOCAL USE

33 FEDERAL TAX ID NUMBER 34 PATIENT ACCOUNT NO 35 ACCOUNT ASSIGNMENT (YES NO) 36 TOTAL CHARGE \$ 37 AMOUNT PAID \$ 38 BALANCE DUE \$

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629 FEDERAL TAX ID NUMBER 630 PATIENT ACCOUNT NO 631 ACCOUNT ASSIGNMENT (YES NO) 632 TOTAL CHARGE \$ 633 AMOUNT PAID \$ 634 BALANCE DUE \$

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638 FEDERAL TAX ID NUMBER 639 PATIENT ACCOUNT NO 640 ACCOUNT ASSIGNMENT (YES NO) 641 TOTAL CHARGE \$ 642 AMOUNT PAID \$ 643 BALANCE DUE \$

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647 FEDERAL TAX ID NUMBER 648 PATIENT ACCOUNT NO 649 ACCOUNT ASSIGNMENT (YES NO) 650 TOTAL CHARGE \$ 651 AMOUNT PAID \$ 652 BALANCE DUE \$

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665 FEDERAL TAX ID NUMBER 666 PATIENT ACCOUNT NO 667 ACCOUNT ASSIGNMENT (YES NO) 668 TOTAL CHARGE \$ 669 AMOUNT PAID \$ 670 BALANCE DUE \$

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674 FEDERAL TAX ID NUMBER 675 PATIENT ACCOUNT NO 676 ACCOUNT ASSIGNMENT (YES NO) 677 TOTAL CHARGE \$ 678 AMOUNT PAID \$ 679 BALANCE DUE \$

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783 FEDERAL TAX ID NUMBER 784 PATIENT ACCOUNT NO 785 ACCOUNT ASSIGNMENT (YES NO) 786 TOTAL CHARGE \$ 787 AMOUNT PAID \$ 788 BALANCE DUE \$

789 SIGNATURE OF PHYSICIAN OR SUPPLIER 790 DATE SIGNED 791 NAME AND ADDRESS OF FACILITY

793 FEDERAL TAX ID NUMBER 794 PATIENT ACCOUNT NO 795 ACCOUNT ASSIGNMENT (YES NO) 796 TOTAL CHARGE \$ 797 AMOUNT PAID \$ 798 BALANCE DUE \$

799 SIGNATURE OF PHYSICIAN OR SUPPLIER 800 DATE SIGNED 801 NAME AND ADDRESS OF FACILITY

802 FEDERAL TAX ID NUMBER 803 PATIENT ACCOUNT NO 804 ACCOUNT ASSIGNMENT (YES NO) 805 TOTAL CHARGE \$ 806 AMOUNT PAID \$ 807 BALANCE DUE \$

808 SIGNATURE OF PHYSICIAN OR SUPPLIER 809 DATE SIGNED 810 NAME AND ADDRESS OF FACILITY

811 FEDERAL TAX ID NUMBER 812 PATIENT ACCOUNT NO 813 ACCOUNT ASSIGNMENT (YES NO) 814 TOTAL CHARGE \$ 815 AMOUNT PAID \$ 816 BALANCE DUE \$

817 SIGNATURE OF PHYSICIAN OR SUPPLIER 818 DATE SIGNED 819 NAME AND ADDRESS OF FACILITY

820 FEDERAL TAX ID NUMBER 821 PATIENT ACCOUNT NO 822 ACCOUNT ASSIGNMENT (YES NO) 823 TOTAL CHARGE \$ 824 AMOUNT PAID \$ 825 BALANCE DUE \$

826 SIGNATURE OF PHYSICIAN OR SUPPLIER 827 DATE SIGNED 828 NAME AND ADDRESS OF FACILITY

829 FEDERAL TAX ID NUMBER 830 PATIENT ACCOUNT NO 831 ACCOUNT ASSIGNMENT (YES NO) 832 TOTAL CHARGE \$ 833 AMOUNT PAID \$ 834 BALANCE DUE \$

835 SIGNATURE OF PHYSICIAN OR SUPPLIER 836 DATE SIGNED 837 NAME AND ADDRESS OF FACILITY

838 FEDERAL TAX ID NUMBER 839 PATIENT ACCOUNT NO 840 ACCOUNT ASSIGNMENT (YES NO) 841 TOTAL CHARGE \$ 842 AMOUNT PAID \$ 843 BALANCE DUE \$

844 SIGNATURE OF PHYSICIAN OR SUPPLIER 845 DATE SIGNED 846 NAME AND ADDRESS OF FACILITY

847 FEDERAL TAX ID NUMBER 848 PATIENT ACCOUNT NO 849 ACCOUNT ASSIGNMENT (YES NO) 850 TOTAL CHARGE \$ 851 AMOUNT PAID \$ 852 BALANCE DUE \$

853 SIGNATURE OF PHYSICIAN OR SUPPLIER 854 DATE SIGNED 855 NAME AND ADDRESS OF FACILITY

856 FEDERAL TAX ID NUMBER 857 PATIENT ACCOUNT NO 858 ACCOUNT ASSIGNMENT (YES NO) 859 TOTAL CHARGE \$ 860 AMOUNT PAID \$ 861 BALANCE DUE \$

862 SIGNATURE OF PHYSICIAN OR SUPPLIER 863 DATE SIGNED 864 NAME AND ADDRESS OF FACILITY

865 FEDERAL TAX ID NUMBER 866 PATIENT ACCOUNT NO 867 ACCOUNT ASSIGNMENT (YES NO) 868 TOTAL CHARGE \$ 869 AMOUNT PAID \$ 870 BALANCE DUE \$

871 SIGNATURE OF PHYSICIAN OR SUPPLIER 872 DATE SIGNED 873 NAME AND ADDRESS OF FACILITY

874 FEDERAL TAX ID NUMBER 875 PATIENT ACCOUNT NO 876 ACCOUNT ASSIGNMENT (YES NO) 877 TOTAL CHARGE \$ 878 AMOUNT PAID \$ 879 BALANCE DUE \$

880 SIGNATURE OF PHYSICIAN OR SUPPLIER 881 DATE SIGNED 882 NAME AND ADDRESS OF FACILITY

883 FEDERAL TAX ID NUMBER 884 PATIENT ACCOUNT NO 885 ACCOUNT ASSIGNMENT (YES NO) 886 TOTAL CHARGE \$ 887 AMOUNT PAID \$ 888 BALANCE DUE \$

889 SIGNATURE OF PHYSICIAN OR SUPPLIER 890 DATE SIGNED 891 NAME AND ADDRESS OF FACILITY

893 FEDERAL TAX ID NUMBER 894 PATIENT ACCOUNT NO 895 ACCOUNT ASSIGNMENT (YES NO) 896 TOTAL CHARGE \$ 897 AMOUNT PAID \$ 898 BALANCE DUE \$

899 SIGNATURE OF PHYSICIAN OR SUPPLIER 900 DATE SIGNED 901 NAME AND ADDRESS OF FACILITY

902 FEDERAL TAX ID NUMBER 903 PATIENT ACCOUNT NO 904 ACCOUNT ASSIGNMENT (YES NO) 905 TOTAL CHARGE \$ 906 AMOUNT PAID \$ 907 BALANCE DUE \$

908 SIGNATURE OF PHYSICIAN OR SUPPLIER 909 DATE SIGNED 910 NAME AND ADDRESS OF FACILITY

911 FEDERAL TAX ID NUMBER 912 PATIENT ACCOUNT NO 913 ACCOUNT ASSIGNMENT (YES NO) 914 TOTAL CHARGE \$ 915 AMOUNT PAID \$ 916 BALANCE DUE \$

917 SIGNATURE OF PHYSICIAN OR SUPPLIER 918 DATE SIGNED 919 NAME AND ADDRESS OF FACILITY

920 FEDERAL TAX ID NUMBER 921 PATIENT ACCOUNT NO 922 ACCOUNT ASSIGNMENT (YES NO) 923 TOTAL CHARGE \$ 924 AMOUNT PAID \$ 925 BALANCE DUE \$

926 SIGNATURE OF PHYSICIAN OR SUPPLIER 927 DATE SIGNED 928 NAME AND ADDRESS OF FACILITY

929 FEDERAL TAX ID NUMBER 930 PATIENT ACCOUNT NO 931 ACCOUNT ASSIGNMENT (YES NO) 932 TOTAL CHARGE \$ 933 AMOUNT PAID \$ 934 BALANCE DUE \$

935 SIGNATURE OF PHYSICIAN OR SUPPLIER 936 DATE SIGNED 937 NAME AND ADDRESS OF FACILITY

938 FEDERAL TAX ID NUMBER 939 PATIENT ACCOUNT NO 940 ACCOUNT ASSIGNMENT (YES NO) 941 TOTAL CHARGE \$ 942 AMOUNT PAID \$ 943 BALANCE DUE \$

944 SIGNATURE OF PHYSICIAN OR SUPPLIER 945 DATE SIGNED 946 NAME AND ADDRESS OF FACILITY

947 FEDERAL TAX ID NUMBER 948 PATIENT ACCOUNT NO 949 ACCOUNT ASSIGNMENT (YES NO) 950 TOTAL CHARGE \$ 951 AMOUNT PAID \$ 952 BALANCE DUE \$

953 SIGNATURE OF PHYSICIAN OR SUPPLIER 954 DATE SIGNED 955 NAME AND ADDRESS OF FACILITY

956 FEDERAL TAX ID NUMBER 957 PATIENT ACCOUNT NO 958 ACCOUNT ASSIGNMENT (YES NO) 959 TOTAL CHARGE \$ 960 AMOUNT PAID \$ 961 BALANCE DUE \$

962 SIGNATURE OF PHYSICIAN OR SUPPLIER 963 DATE SIGNED 964 NAME AND ADDRESS OF FACILITY

965 FEDERAL TAX ID NUMBER 966 PATIENT ACCOUNT NO 967 ACCOUNT ASSIGNMENT (YES NO) 968 TOTAL CHARGE \$ 969 AMOUNT PAID \$ 970 BALANCE DUE \$

971 SIGNATURE OF PHYSICIAN OR SUPPLIER 972 DATE SIGNED 973 NAME AND ADDRESS OF FACILITY

974 FEDERAL TAX ID NUMBER 975 PATIENT ACCOUNT NO 976 ACCOUNT ASSIGNMENT (YES NO) 977 TOTAL CHARGE \$ 978 AMOUNT PAID \$ 979 BALANCE DUE \$

980 SIGNATURE OF PHYSICIAN OR SUPPLIER 981 DATE SIGNED 982 NAME AND ADDRESS OF FACILITY

983 FEDERAL TAX ID NUMBER 984 PATIENT ACCOUNT NO 985 ACCOUNT ASSIGNMENT (YES NO) 986 TOTAL CHARGE \$ 987 AMOUNT PAID \$ 988 BALANCE DUE \$

989 SIGNATURE OF PHYSICIAN OR SUPPLIER 990 DATE SIGNED 991 NAME AND ADDRESS OF FACILITY

993 FEDERAL TAX ID NUMBER 994 PATIENT ACCOUNT NO 995 ACCOUNT ASSIGNMENT (YES NO) 996 TOTAL CHARGE \$ 997 AMOUNT PAID \$ 998 BALANCE DUE \$

999 SIGNATURE OF PHYSICIAN OR SUPPLIER 1000 DATE SIGNED 1001 NAME AND ADDRESS OF FACILITY

SAMPLE EOB (EXPLANATION OF BENEFITS)

**UnitedHealthcare**  
A UnitedHealth Group Company

**UNITEDHEALTHCARE SERVICE LLC**  
GREENSBORO SERVICE CENTER  
P O BOX 740800  
ATLANTA, GA 30374-0800  
PHONE: 1-800-638-8010  
VISIT WWW.MYUHC.COM FOR SELF SERVICE

PAGE: 1 OF 1  
DATE: 04/29/10  
SSN/ID #: \_\_\_\_\_  
EMPLOYEE: \_\_\_\_\_  
CONTRACT: \_\_\_\_\_  
BENEFIT PLAN: PFIZER INC

**EXPLANATION OF BENEFITS**

PATIENT/RELAT CLAIM NUMBER	PROVIDER/SERVICE	DATE OF SERVICE	SERVICE DETAIL		AMOUNT ALLOWED	COPAY/Deductible	PLAN COVERS	BENEFIT AVAILABLE	REMARK CODE
			AMOUNT CHARGED	NOT COVERED					
9061512101	MEDICAL SERVICES	05/19/10					80%	64.94	4C
			TOTAL	379.00	297.83	81.17	64.94		
							MEDICARE PAID	44.64	
							PLAN PAYS	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 COPAYS BEFORE THIS PLAN CAN PAY ANY BENEFITS.

**BENEFIT PLAN PAYMENT SUMMARY INFORMATION**  
\$20.30

SATISFIED 2010 TO-DATE	DEDUCTIBLE	OUT OF POCKET	
		FAMILY	INDIV
FAMILY	\$1000.00	\$1328.77	\$1281.45
SP	\$500.00		
PLAN YEAR 2010	FAMILY \$1000.00	FAMILY \$4000.00	
	INDIV \$500.00	INDIV \$4000.00	



STUDENT ACCIDENT INSURANCE 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

IMPORTANT NOTICE:

Your insurance plan is designed to provide maximum benefits for minimum premium. This plan of insurance is secondary 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 Name Policy Number

District Name Phone No. ( )

Address Email

Type of Activity/Sport

If Athletics, designate P.E. Class Intramural Interscholastic 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

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

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 #
_____	_____	_____
_____	_____	_____

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: \_\_\_\_\_

## FRAUD NOTICE STATEMENTS

**NOTICE TO APPLICANTS:** "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."

**RESIDENTS OF ALABAMA APPLICANTS:** "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."

**RESIDENTS OF ALASKA APPLICANTS:** "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."

**RESIDENTS OF ARKANSAS APPLICANTS:** "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."

**RESIDENTS OF ARIZONA APPLICANTS:** "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."

**RESIDENTS OF COLORADO APPLICANTS:** "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."

**RESIDENTS OF CALIFORNIA APPLICANTS:** "FOR YOUR PROTECTION CALIFORNIA LAW REQUIRES THE FOLLOWING TO APPEAR ON THIS FORM. ANY PERSON WHO KNOWINGLY PRESENTS 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."

**RESIDENTS OF DELAWARE APPLICANTS:** "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."

**RESIDENTS OF DISTRICT OF COLUMBIA APPLICANTS:** "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."

**RESIDENTS OF FLORIDA APPLICANTS:** "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."

**RESIDENTS OF IDAHO APPLICANTS:** "ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO DEFRAUD OR DECEIVE ANY INSURANCE COMPANY, FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION IS GUILTY OF A FELONY."

**RESIDENTS OF INDIANA APPLICANTS:** "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."

**RESIDENTS OF KENTUCKY APPLICANTS:** "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."

**RESIDENTS OF LOUISIANA APPLICANTS:** "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."

**RESIDENTS OF MAINE APPLICANTS:** "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."

**RESIDENTS OF MARYLAND APPLICANTS:** "ANY PERSON WHO KNOWINGLY AND WILLFULLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY AND WILLFULLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON."

**RESIDENTS OF MINNESOTA APPLICANTS:** "A PERSON WHO FILES A CLAIM WITH INTENT TO DEFRAUD OR HELPS COMMIT A FRAUD AGAINST AN INSURER IS GUILTY OF A CRIME."

**RESIDENTS OF NEVADA APPLICANTS:** ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY MISREPRESENTATION OR ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION MAY BE GUILTY OF A CRIMINAL ACT PUNISHABLE UNDER STATE OR FEDERAL LAW, OR BOTH, AND MAY BE SUBJECT TO CIVIL PENALTIES."

**RESIDENTS OF NEW HAMPSHIRE APPLICANTS:** "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."

**RESIDENTS OF NEW JERSEY APPLICANTS:** "ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE OR MISLEADING INFORMATION IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES."

**RESIDENTS OF NEW MEXICO APPLICANTS:** "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."

**RESIDENTS OF NEW YORK APPLICANTS:** "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."

**RESIDENTS OF OHIO APPLICANTS:** "ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST ANY INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD."

**RESIDENTS OF OKLAHOMA APPLICANTS:** "WARNING. 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."

**RESIDENTS OF OREGON APPLICANTS:** "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 MAY BE SUBJECT TO PROSECUTION FOR INSURANCE FRAUD."

**RESIDENTS OF PENNSYLVANIA APPLICANTS:** "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."

**RESIDENTS OF RHODE ISLAND APPLICANTS:** "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."

**RESIDENTS OF TENNESSEE APPLICANTS:** "IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS."

**RESIDENTS OF TEXAS APPLICANTS:** "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."

**RESIDENTS OF VIRGINIA APPLICANTS:** "IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS."

**RESIDENTS OF WASHINGTON APPLICANTS:** "IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSES OF DEFRAUDING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES, AND DENIAL OF INSURANCE BENEFITS."

**RESIDENTS OF WEST VIRGINIA APPLICANTS:** "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."