MAIL CLAIM FORMS TO: Co-ordinated Benefit Plans, PO Box 20874, Tampa, FL 33623
IF YOU NEED ASSISTANCE: TOLL FREE 1-877 902-9926 / EMAIL: TEAM2@CBPINSURE.COM

TEXAS K-12 CLAIMANT'S NOTICE OF ACCIDENT

PART A Claim Form

1. FULL NAME (Injured Person)	**2. DATE OF BIRTH**	**3. TELEPHONE NUMBER** ( )
4. EMAIL ADDRESS	**5. SECONDARY EMAIL ADDRESS**	
6. STREET ADDRESS	**7. CITY, STATE, ZIP**	
8. POLICY HOLDER'S NAME		
9. POLICY NUMBER	**10. DATE OF INJURY** _____/_____/_____	**11. TIME OF INJURY** _____ **AM / PM**
12. IF HOSPITALIZED, HOSPITAL NAME **HOSPITAL TEL. NO. ( )**	**13. STREET ADDRESS**	
14. CITY, STATE, ZIP	**15. HOSPITAL CONFINEMENT DATES** **From: | To:**	
16. Explain HOW the accident and injury occurred. NOTE: If your organization uses an Accident Report Form, attach a copy of the Report.		
17. Describe the nature of injury.		
18. At what location did the injury occur?		

AUTHORIZED SCHOOL ADMINISTRATOR

_____	_____	_____	( )_____
Date	Print Name	Signature	Telephone#

NOTICE

This claim form MUST be received by the Insurance Company within 90 days of the date of injury. Benefits will be paid for eligible expenses left unpaid by other insurance or health plans. Expenses must be incurred within 52 weeks after the date of the accident.

CLAIM PROCEDURE

1. Have an AUTHORIZED SCHOOL ADMINISTRATOR **complete, date** and **sign** PART A.
2. The Injured Person (Insured) – or, if the Injured Person is under age 18 or is otherwise dependent, his/her Parent or Guardian – MUST **complete, date** and **sign** PART B.
3. Send all medical bills to your other health and accident insurance company(s) **first**, if applicable. This can include employee plans, union plans, service contracts, H.M.O. Plans, self-insured benefit plans, etc.
4. After you have received a notice of payment, notice of denial or letter stating you have met your deductible from your other insurance company(s), forward that statement, along with copies of the original bills, to the address shown above.

PART B – This PART MUST be completed, dated and signed by the Injured Person – or if the Injured Person is under age 18 or otherwise dependent – by his/her Parent or Guardian.

PRINT HERE – NAME OF PERSON COMPLETING FORM: Check one: Injured Person □ Parent □ Guardian □

Give the following information about the Injured Person:

1. Date of Birth Mo. Day Year / /	2. Male □ Female □	3. Social Security No. / /	4. Area Code/Telephone No. ( ) _____

5. Employer (Name) ADDRESS: (Street) (City) (State) (Zip)
(if applicable)

Area Code/Employer Telephone No.
( )_____

6. Is the Injured Person covered under any other health and/or accident insurance plans? Yes □ No □
If YES, give the following information:

Name of Other Insurance Company(s) Address Policy Number(s)

Policyholder Name and Address Social Security No.
/ /

Relationship to Injured person: Area Code/Telephone No.
( )_____

7. If the Injured Person is married, give the following information:
Name of Spouse Social Security No.
/ /

Area Code/Telephone No.
( )_____

I authorize any insurer, hospital, physician or other person who has attended or examined the Insured Person to disclose, when requested to do so, all information with respect to any injury, policy coverages, medical history, consultation, prescription or treatment, and copies of all hospital or medical records and itemized bills. A photostatic copy of this authorization shall be considered as effective and valid as the original. The above information is true and complete to the best of my knowledge and belief.

I also Authorize Aegis Security Insurance Company of Pennsylvania or its representatives to pay all bills in connection with this claim directly to the doctor, hospital or any other persons rendering service, and such payment shall release Aegis Security Insurance Company of Pennsylvania from liability as to amounts so paid.

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 (in FL, a felony in the third degree), and in the state of New York, 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.

□ Injured Person

X_____ _____ Check one: □ Parent Date:_____

Signature (in writing) of Responsible Party Print Name □ Guardian

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.