

How to File a Medical Claim

Wilson Sports Texas Student Accident Insurance Program



(52 Week Benefit Period; 1st expense incurred within 26 weeks of accident)

Attached is a Blanket Lines Notice of Claim (Claim Form) for your accident policy
Please forward claims and questions to the following address:

Fringe Benefit Coordinators, Inc.
P. O. Box 5249, Gainesville, FL 32627-5249
Toll Free Number (800) 654-1452
Fax Number (352) 372-9805

Step 1 - Submit a completed Notice of Claim (claim form) to our office either by fax or mail

The Policyholder's School Official/Trainer (not the Parent, Claimant or Agent) should:

- In the Policyholder Certification section of the form, fully answer each question and sign the Policyholder Certification Statement.

The Parent/Guardian (not the Policyholder or Agent) should:

- In the Claimant Certification section of the form, fully answer each question and sign the Parent/Guardian Certification Statement.

Step 2 - Submit itemized medical bills for payment consideration to our office. This policy was issued on an Excess basis, so please also include any other insurance carrier's corresponding Explanation of Benefits (EOBs), as outlined in the helpful information bullet listed below.

Helpful information for submitting claims and expediting payment

- A complete Notice of Claim is required for each accident/injury a Claimant incurs.
- Proof of Lost must be submitted within 90 days.
- Providers may wish to bill us directly for their services. If they do, please ensure a Notice of Claim has first been submitted to our office.
- Itemized medical bills (including claimant name, date of service, diagnosis, procedure codes, amount charged, and provider information) should be submitted for processing. "Balance Due" statements and/or incomplete bills do not provide enough claim detail to process the charges. In order to ensure we receive complete claim information, we suggest providers submit standardized billing statements (called "UB-04" for hospital charges and/or a "CMS-1500" for physician charges).
- For Excess Policies, if the Claimant has other insurance coverage, medical bills should first be submitted to your other insurance carrier for payment. Once they have processed the charges (either paid or denied), then submit a copy of your provider's itemized medical bill and the other carrier's coordinating Explanation of Benefits (EOB) to our office for processing. Important - we are unable to make a claim determination without both of these items; claim payment will be expedited if the medical bill and EOB are the submitted at the same time.
- Unless proof of payment is submitted with the medical bill (a copy of check, a medical bill that indicates the claimant has made all or partial payment or zero balance information) claim payment is generally sent directly to the medical providers.

Please detach this page and forward the completed Notice of Claim (and medical bills if you are submitting expenses for payment) to the address listed above. We recommend you keep copies of the correspondence you are submitting to use for future reference.

HARTFORD LIFE & ACCIDENT INSURANCE COMPANY

Notice of Claim

Wilson Sports Texas Student Accident Insurance Program

Fringe Benefit Coordinators, Inc., P. O. Box 5249, Gainesville, FL 32627-5249
Toll Free Number (800) 654-1452 Fax Number (352) 372-9805



**THE
HARTFORD**

POLICYHOLDER CERTIFICATION - To be completed by School Official/Trainer

Policyholder Number		Policyholder Name (School District)	
School Name		School Official/Trainer Telephone Number ()	
Has Claimant elected voluntary coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, check all that apply <input type="checkbox"/> 24 Hour <input type="checkbox"/> School Time <input type="checkbox"/> Extended Dental			
Claimant (Injured Party) Name		Claimant Date of Birth	Claimant Telephone Number ()
Claimant Address (Street, Number, City, State, Zip)			
Date of Accident (mm/dd/yyyy)	Time of Accident (hh:mm) _____ <input type="checkbox"/> AM <input type="checkbox"/> PM	Place of Accident	Field Trip <input type="checkbox"/> Yes <input type="checkbox"/> No
Cause of Accident		Indicate injured body part(s)	Sport or Activity Type
Nature of Sickness (if applicable)			Date Sickness first commenced
<i>Policyholder Certification Statement (Signature Required)</i>			
This Claimant is a member of the group insured under the above Policy and the injury/sickness was sustained under adequate supervision while participating in an official Covered Activity.			
Texas law requires we advise you the following information regarding fraud: 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.			
I hereby certify the above statements made by and certified by me to be true to the best of my knowledge. I am aware that if any of the foregoing statements on this form made by me are willfully false, I may be subject to penalties, which may include criminal prosecution.			
Title of Policyholder Official/Trainer		Signature of Policyholder Official/Trainer	Date

CLAIMANT CERTIFICATION - To be completed by Parent/Guardian

New government regulations require Social Security Numbers for all claimants. Claims submitted without this will be returned.

Claimant Name		Claimant Date of Birth	Claimant Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
*Is the Claimant a Medicare Beneficiary? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, please provide Claimant's Social Security Number or Health Identification Claim Number _____			
Claimant Daytime Phone Number ()	Claimant Address (Street, Number, City, State, Zip)		
Does the Claimant have medical coverage through?			
Mother's employers policy* <input type="checkbox"/> Yes <input type="checkbox"/> No	Father's employers policy* <input type="checkbox"/> Yes <input type="checkbox"/> No		
Guardian's employers policy* <input type="checkbox"/> Yes <input type="checkbox"/> No	Any other medical policy* <input type="checkbox"/> Yes <input type="checkbox"/> No		
Medicaid policy <input type="checkbox"/> Yes <input type="checkbox"/> No	Medicare policy <input type="checkbox"/> Yes <input type="checkbox"/> No		
*If yes, please include the other insurance carrier's Explanation of Benefits (EOBs) for each medical bill submitted.			
<i>Parent/Guardian Certification Statement (Signature Required)</i>			
I authorize any physician/hospital that has attended my dependent child to disclose information thus acquired for the purpose of this claim payment.			
Texas law requires we advise you the following information regarding fraud: 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.			
I hereby certify the above statements made by and certified by me to be true to the best of my knowledge. I am aware that if any of the foregoing statements on this form made by me are willfully false, I may be subject to penalties, which may include criminal prosecution.			
Printed Name of Parent/Guardian		Signature of Parent/Guardian	Date

Signature - Please read the statement that applies to your state of residence and sign the bottom of the page.

With the exception of any source(s) of income reported above in this form, I certify by my signature that I have not received and am not eligible to receive any source of income, except for my disability benefits from this plan. Further, I understand that should I receive income of any kind or perform work of any kind during any period The Hartford has approved my disability claim, I must report all details to The Hartford, immediately. If I receive disability income benefits greater than those which should have been paid, I understand that I will be required to provide a lump sum repayment to the Plan. The Hartford has the option to reduce or eliminate future disability payments in order to recover any overpayment balance that is not reimbursed.

For residents of all states EXCEPT Arizona, California, Colorado, Florida, Kentucky, Maine, Maryland, New Jersey, New York, Oregon, Pennsylvania, Puerto Rico, Tennessee, Virginia and Washington: 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.

For Residents of 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.

For Residents of California: 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.

For residents of 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 award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

For residents of 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.

For residents of Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim or an application for insurance 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.

For residents of 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 and denial of insurance benefits.

For Residents of Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit and 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.

For residents of New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. Any person who includes any false or misleading information on an application for insurance policy is subject to criminal and civil penalties.

For residents of New York: 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.

For residents of Oregon: 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 that the insurer relied upon is subject to a denial and/or reduction in insurance benefits and may be subject to any civil penalties available.

For residents of 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 hereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

For residents of Puerto Rico: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars (\$5,000) and not more than ten thousand dollars (\$10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

The statements contained in this form are true and complete to the best of my knowledge and belief.

Signature _____

Date _____

Electronic Funds Transfer (EFT) is our standard method of payment. When making our claim decision we may contact you to obtain your banking information.