

Administered by:

COMMERCIAL TRAVELERS
LIFE INSURANCE COMPANY

In order to receive benefits based on the School's Student Accident Policy, **all medical bills must be first submitted to the student's own health insurance carrier providing the student's primary medical coverage.** Student Accident Insurance is intended to be a supplemental coverage to your primary carrier's coverage, therefore, benefits will not be paid for medical expenses covered by your own health insurance.

When we are the secondary plan, we do not pay until after the primary plan has paid its benefits if any. We will review Usual & Reasonable charges of each plan and allow the highest. Any amount paid by your primary plan for an eligible expense under our plan may satisfy all or a portion of our deductible.

Student Accident Insurance is administered by Commercial Travelers Life Insurance Company. In order to claim expenses not covered by your primary health insurance, the following steps must be followed:

- School Official completes the Student Accident Report.
- Submitting the appropriate documentation is essential for timely adjudication of your claim expenses. Please note: If you are receiving treatment from a provider (primary care physician), please request a CMS 1500 (see attached example). If you are receiving treatment from a hospital, please request a UB04 (see attached example).
- Please submit any Notice of Payment or Rejection (explanation of benefits—EOB) forms from your primary health insurance carrier. Any itemized billing statements submitted must include a diagnosis code and procedure code.
- Please notify all physicians, hospitals and any other healthcare providers that have or will be treating you and provide them the insurance information about the school's accident insurance carrier. Please ask the providers to bill the claims administrator as secondary insurance at the following address:

Commercial Travelers Life Insurance Company
Attn: Claim Administration
70 Genesee Street
Utica NY 13502
Fax No. 315-797-0195
claims@commercialtravelers.com

Should you have any questions or concerns regarding your coverage or claim, please call the claims administrator, Commercial Travelers Life Insurance Company at 1-800-756-3702.

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COMMERCIAL TRAVELERS
LIFE INSURANCE COMPANY

**70 GENESEE STREET
UTICA, NEW YORK 13502**

For Toll-free Policyholder Service 1-800-756-3702 • Utica area 315-797-5200

Underwritten by: NATIONAL GUARDIAN LIFE INSURANCE COMPANY

Instructions

1. Form must be completed by a school official/athletic director.
2. Include copies of itemized bills that include a diagnosis.
3. Include copies of Explanation of Benefits statements from your Primary insurance carrier—one for each bill.
4. Later itemized bills and Explanation of Benefit statements can be mailed separately. Make sure the name of the student is on all correspondence.
5. If you have submitted an accident report to another insurance company, please attach a copy.
6. Save copies of submitted materials for your records.

Student Accident Report

School Report

Name of College or University _____ Policy # _____

Name of Student _____ Male Female
First Middle Initial Last

Student School Address _____
Street City State Zip

Student Home Address _____
Street City State Zip

Date of Birth _____ Email Address _____

Cell Phone No. _____ Social Security No. _____ Student ID No. _____

Place of Accident _____ Accident Date _____

Circumstance: Game Practice Conditioning Other Type of Injury: Club Sport Intramural
 Intercollegiate Non-athletic

Body Part Injured _____ Name of Sport (if Athletic) _____

Nature of — Details of What Happened _____

Treated or referred by the Student Health Center Yes No Date of treatment or referral _____

Name of School Official or Coach Supervising the Activity _____

INSURANCE INFORMATION

Does the claimant have primary insurance? Yes No *(Attach separate sheet if necessary.)*

Insurance Company Name & Address _____

Policy Number _____ ID No. _____

I hereby certify that I have read the answers to all parts of this form and to the best of my knowledge and belief the information is complete and correct as given herein.

Any person who includes any false or misleading information on an application or statement of claim for an insurance policy is subject to criminal and civil penalties.

Signature of School Official/Title _____ Date Signed _____

AK, CT, DE, HI, IA, ID, IL, IN, MI, MN, MO, MT, MS, NC, ND, NV, SC, SD, UT, WI & WY: Any person who knowingly and with intent to defraud an insurer submits a written application or claim containing any materially false or misleading information is guilty of insurance fraud.

AL, AR, DC, LA, MA, and RI: 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.

AZ: 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.

CA: For your protection California law requires the following to appear on this form: 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.

CO: 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."

FL: 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.

GA, NE, KS, OR, TX, VT: Any person who knowingly and with intent to defraud an insurer submits a written application or claim containing any materially false or misleading information may be guilty of insurance fraud.

KY: Any person who knowingly and with intent to defraud any insurance company or other person files 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.

ME: 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.

MD: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or 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.

NH: 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.

NJ: Any person who includes any false or misleading information on an application or statement of claim for an insurance policy is subject to criminal and civil penalties.

NM: 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.

NY: Any person who knowingly and with intent to defraud any insurance company or other person files an application for health insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, any 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 \$5,000.00 and the stated value of the claim for each such violation.

OH: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

PA: 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.

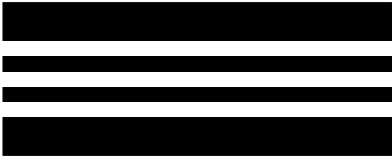
OK: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

TN: 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.

VA, WA: 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 or a denial of insurance benefits.

WV: 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.

PLEASE DO NOT STAPLE IN THIS AREA



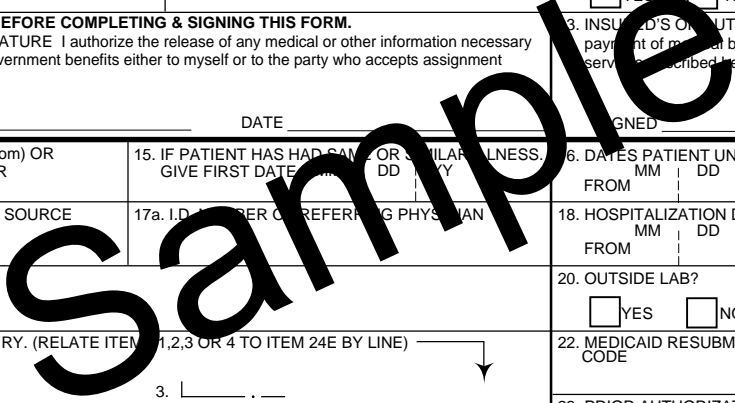
CARRIER

HEALTH INSURANCE CLAIM FORM

1. MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
3. PATIENT'S BIRTH DATE MM DD YY SEX M F
4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)
6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other
7. INSURED'S ADDRESS (No., Street)
8. PATIENT STATUS Single Married Other
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)
10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)
15. IF PATIENT HAS HAD SIMILAR ILLNESS OR INJURY GIVE FIRST DATE
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE
17a. I.D. NUMBER OF REFERRING PHYSICIAN
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
19. RESERVED FOR LOCAL USE
20. OUTSIDE LAB? \$ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEM 1, 2, 3 OR 4 TO ITEM 24E BY LINE)
22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER



24. TABLE with columns A through K: DATE(S) OF SERVICE, Place of Service, Type of Service, PROCEDURES, SERVICES, OR SUPPLIES (CPT/HCPCS MODIFIER), DIAGNOSIS CODE, \$ CHARGES, DAYS OR UNITS, EPSDT Family Plan, EMG, COB, RESERVED FOR LOCAL USE

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN
26. PATIENT'S ACCOUNT NO.
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO
28. TOTAL CHARGE \$
29. AMOUNT PAID \$
30. BALANCE DUE \$
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS
32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED
33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

SIGNED DATE PIN# GRP#

1	2	3a PAT. CNTL. #	4 TYPE OF BILL
		b. MED. REC. #	
		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM
			7 THROUGH
8 PATIENT NAME	a	9 PATIENT ADDRESS	a
b	b	c	d
10 BIRTHDATE	11 SEX	12 DATE	13 HR
14 TYPE	15 SRC	16 DHR	17 STAT
18	19	20	21
22	23	24	25
26	27	28	29 ACDT STATE
30			
31 OCCURRENCE CODE	32 OCCURRENCE DATE	33 OCCURRENCE CODE	34 OCCURRENCE DATE
35 CODE	36 OCCURRENCE SPAN FROM	37 THROUGH	38
39 CODE	40 VALUE CODES AMOUNT	41 CODE	42 VALUE CODES AMOUNT
a			
b			
c			
d			

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1							1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
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18							18
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20							20
21							21
22							22
23	PAGE ____ OF ____	CREATION DATE	TOTALS →				23

Sample

50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI
A						57 OTHER PRV ID
B						
C						
58 INSURED'S NAME	59 P.REL.	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.		
A						
B						
C						
63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME				
A						
B						
C						
66 DX	67	A	B	C	D	E
		F	G	H	I	J
		K	L	M	N	O
		P	Q	R	S	T
69 ADMIT DX	70 PATIENT REASON DX	a	b	c	71 PPS CODE	72 ECI
74 PRINCIPAL PROCEDURE CODE	75 OTHER PROCEDURE CODE	76 ATTENDING NPI	77 OPERATING NPI	78 OTHER NPI	79 OTHER NPI	80 QUAL
c.	d.	e.				
80 REMARKS	81CC a	b	c	d		