HAMBLEN COUNTY DEPARTMENT OF EDUCATION

210 East Morris Boulevard
Morristown, Tennessee 37813
Phone (423) 586-7700 • Fax (423) 586-7747

The mission of Hamblen County Schools is to educate students so they can be challenged to successfully compete in their chosen fields.

Dear Parent/Guardian,
Attached please find a summary of benefits and limitations concerning the athletic insurance policy provided by the Hamblen County Board of Education. Please review these benefits and the procedures for filing claims carefully. After reviewing the summary, please sign the statement below and return this sheet to your child's coach. Thank you for your assistance.

Affirmation

By signing below, I acknowledge that I have read and understand the benefit summary concerning the athletic insurance policy provided by the Hamblen County Board of Education. I understand that this policy is secondary to any other insurance policy I may have and benefits will be paid as set forth in the benefit summary. I also understand that all costs incurred may not be covered by the secondary policy.

_____
Print (Student's Name)

_____
Print (Parent's/Guardian's Name)

_____
Signature (Parent/Guardian)

_____
Date

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Estimado Padre/Guardián,
Conectado usted encuentra un resumen de beneficios y limitaciones con respecto a la póliza de seguros atlética proporcionado por la Mesa de Educación de Condado de Hamblen. Revise por favor estos beneficios y los procedimientos para ser reclamos. Después de revisar el resumen, firme la declaración abajo y regrese esta hoja al entrenador de su niño. Gracias por su ayuda.

Afirmación

Firmando abajo, reconozco que he leído y he comprendido el resumen de beneficio con respecto a la póliza de seguros atlética proporcionado por la Mesa de Educación de Condado de Hamblen. Comprendo que esta política es secundaria a cualquier otra póliza de seguros yo puedo tener y los beneficios serán pagados como exponen en el resumen de beneficio. Yo también comprendo que todos los gastos contraídos no pueden ser cubiertos por la política secundaria.

_____
(Student's Name) Nombre del Estudiante

_____
(Parent's/Guardian's name) Nombre de Padre/Guardian

_____
(Parent/Guardian Signature) Firma de Padre/Guardian

_____
(Date) Fecha

NOTIFICATION OF INJURY

United States Fire Insurance Company

This Notification of Injury Form is to be used for accident medical claims. **This form and all other correspondence must be submitted within 90 days from the date of accident.**

Policies With Excess Coverage
Eligible covered expenses will be paid only if they are in excess of other valid and collectible insurance or medical payment plan. If the claimant is covered by any other health insurance or medical payment plan they must first submit claim to the primary insurance. After the primary insurance has paid benefits, then submit this claim form along with all EOB's (explanation of benefits) from the primary insurance.

Policies With Primary Coverage
Eligible covered expenses will be paid regardless of other valid and collectible insurance or medical payment plan. There is no need to submit claim to any other insurance.

Claim Form
This Company claim form must be submitted for each individual claim. Part (A) must be completed in full by the Policyholder official or a staff member and signed by the Policyholder official or staff member. Part (B) must be completed in full by the injured person or the parent or guardian if that injured person is a minor and also must be signed. A fully completed claim form is not necessary when submitting additional medical bills; only one claim form is needed per accident/injury.

Medical Bills
Attach all medical bills. All submitted medical bills must be itemized for service. A balance due statement is not acceptable and will only delay processing. A physician's office should submit an invoice per CMS 1500. A hospital and/or emergency room should submit an invoice per UB04. CMS 1500 and UB04 are universal billing forms supplied by the physician's office and/or hospital.

Information Requests
In the event that a claim is not submitted in full or if additional information is needed, the claim will be closed, and the additional information will be requested via US Mail. Please forward the requested information immediately, so that we may finish adjudicating your claim in a swift manner. The explanation of benefits (information request) will be sent to the address of the injured person listed on the claim form in Part (B).

Claim Submission Checklist
Use the below checklist to assure a properly submitted medical claim is to be sent.

If the injured person has primary health insurance has the claim been submitted first to the primary health insurance company?	❑ Yes ❑ No
If claim has first been submitted to the primary health insurance company, are copies of EOB's (explanation of benefits) attached?	❑ Yes ❑ No
Is part (A) of the claim form completed by the Policyholder official or staff member and signed?	❑ Yes ❑ No
Is part (B) of the claim form completed by the injured person and signed?	❑ Yes ❑ No
Are the attached medical bills itemized in either a CMS 1500 or UB04 form?	❑ Yes ❑ No
Is part (B), item number 3 (social security number) completed?	❑ Yes ❑ No

Mailing The Claim
When completed in full, mail the attached completed claim form, itemized medical bills and copies of EOB's (explanation of benefits for use if coverage is excess) to:

The Loomis Company
P.O. Box 14162
Reading, PA. 19612-4162

If you should have any questions, or if a physician's office or hospital needs to confirm benefits before a medical procedure, please contact the claims office at (866) 915-6618.

Documents may also be faxed to the claims office at (610) 370-6767. Please do not fax full medical claims, as often times medical bills are illegible when faxed. For emailing documents, please email suppacc@loomisco.com

PLEASE NOTE: Claims Must Be Submitted Within 90 Days Of The Date Of Accident.

NOTICE

Fraud Warning: Any person who, with the intent to defraud or knowingly facilitates a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, or conceals information for the purpose of misleading may be guilty of insurance fraud and subject to criminal and/or civil penalties.

PART A – This PART **MUST** be **completed, dated** and **signed** by an official or the Organization.

1. Name of Organization and Policy Number				
Hamblen County Board of Education				US061151
2. Address of Organization (Street)		(City)	(State)	(Zip)
210 E. Morris Blvd.		Morristown	TN	37813
3. Name of Injured Person (Insured)	(First)	(Middle)	(Last)	
4. Date of Accident/Injury Mo Day Year / /	5. Injury Occurred: Practice ☐ Travel ☐ Game ☐ Other _____		6. Type of Sport or Activity:	
7. Explain HOW the accident and injury occurred. NOTE: If your organization uses an Accident Report form, attach a copy of the Report.				
8. At the time of the accident, was the Injured Person involved in an activity under the jurisdiction of the Organization (Policyholder)? Yes ☐ No ☐	9. Name of Supervisor of Activity		10. Was he/she a witness to Yes ☐ No ☐	
11. Signature of Organization Official X _____	12. Title of Official	13. Ar a Code/Telephone No. ( )	14. Date Signed	

Form Number USFIC FLD 2011

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. or Student Visa No. / /	4. Area Code/Telephone No. ( )

Please note the Injured Person's Social Security Number MUST be provided as required by the Center for Medicare Services.

5. Address (Street) (City) (State) (Zip)

6. Employer (Name) (Street) (City) (State) (Zip)

Area Code/Employer Telephone No.
( )

7. 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 of Other Insurance Company(s)	Policy Number(s)	Name of Policyholder(s)

8. If the Injured Person is under 18 or otherwise dependent, give the following information:

Name of Father or Male Guardian

Place of Employment

Address of Employer Area Code/Employer Phone No.
( )

Name of Mother or Female Guardian

Place of Employment

Address of Employer Area Code/Employer Phone No.
( )

9. If the Injured Person is married, give the following information:

Name of Wife or Husband

Place of Employment

Address of Employer Area Code/Employer Phone No.
( )

I hereby authorize any physician or medical practitioner, hospital, other organization, institution, or person that has any medical records or knowledge of me or my family as diagnosis, treatment, and prognosis regarding any physical, mental, drug or alcohol condition of any and all such information to be given to United States Fire Insurance Company or its authorized Administrator or their legal representatives. Any information obtained will not be released by the Company except to persons or organizations performing business or legal services in connection with my application or claim. A photocopy of this authorization shall be valid as the original and is valid for 12 months from the date shown below. I understand that my authorized representative or I will receive a copy of this authorization upon request.

☐ Injured Person
☐ Parent
☐ Guardian

X _____ _____ Date: _____

Signature (in writing) of Responsible Party Print Name

Form Number USFIC FLD 2011

Fraud Warning: Any person who, with the intent to defraud or knowingly facilitates a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, or conceals information for the purpose of misleading may be guilty of insurance fraud and subject to criminal and/or civil penalties.

Please see the following for a list of any specific warning as required:

Arizona Residents: 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.

California Residents: 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.

Colorado Residents: 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.

Hawaii Residents: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment or both.

Idaho Residents: Any person who knowingly and with intent to defraud or deceive any insurance company, files a statement or claim containing a false, incomplete, or misleading information is guilty of a felony.

Kentucky Residents: 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.

Oklahoma Residents: 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.

Pennsylvania Residents: 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.

Texas Residents: 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.

SCHEDULE OF BENEFITS

COVERAGE IS PROVIDED UNDER GROUP POLICY NUMBER:	AH-GA26932-002
ISSUED TO GROUP POLICYHOLDER:	The Group and Blanket Accident & Health Insurance Trust
CERTIFICATEHOLDER:	**Hamblen County Board of Education**
CERTIFICATE NUMBER:	**US061151**
CERTIFICATE EFFECTIVE DATE:	**7/1/14**
CERTIFICATE EXPIRATION DATE:	**7/1/15**
BENEFIT PERIOD:	Provided treatment begins within 90 days from the date of Injury, Benefits are payable for 12 months from the date of an Injury. The Injury must occur after the Effective Date and prior to the Expiration Date and care must be Medically Necessary.
DEDUCTIBLE AMOUNT:	$0.00
COINSURANCE PERCENTAGE:	100% of Usual, Reasonable & Customary Charges, URC
MAXIMUM BENEFIT AMOUNT:	$30,000.00

MEDICAL EXPENSE BENEFIT

Hospital Room & Board Daily Maximum Benefit Amount:	URC
Intensive Care Room & Board Daily Maximum Benefit:	URC
Hospital Miscellaneous Maximum Benefit Amount:	URC
Outpatient Pre-Admission Testing Benefit Amount:	URC
Outpatient Hospital Emergency Room Treatment Maximum Benefit Amount:	URC
Surgical Benefits:	
Primary Surgeons Maximum Benefit Amount:	70% of URC
Assistant Surgeon, Second Surgical Opinion, Consultation Maximum Benefit:	35% of Surgeon's Allowance
Anesthesia Maximum Benefit:	35% of Surgeon's Allowance
Surgical Facility Maximum Benefit per Operating Session:	70% of URC
Doctor's Visits	
In-Hospital Maximum Benefit:	URC, up to $70.00 per visit
Office Visits Maximum Benefit:	URC, up to $70.00 per visit
Maximum for All In-Hospital and Office Doctor's Visits:	URC
X-ray Maximum Benefit Amount:	URC, up to $550.00 Per Injury
Laboratory Maximum Benefit Amount:	URC, up to $325.00 Per Injury
Diagnostic Imaging Maximum Benefit Amount:	URC, up to $700.00 Per Injury
Nursing Maximum Benefit Amount:	URC
Physiotherapy Benefit	
Maximum Benefit Amount (Hospital Inpatient):	URC, up to $40.00 Per Visit
Maximum Benefit Amount (Outpatient): URC, up to $40.00 Per Visit	
Maximum for All Physiotherapy Combined (Inpatient & Outpatient):	15 Visit Maximum
Ambulance Maximum Benefit Amount:	URC

Medical Equipment Rental Charges Maximum Benefit Amount:	URC, up to $700.00 Per Injury
Medical Services and Supplies Maximum Benefit Amount (Blood, Blood Transfusions, Oxygen):	URC
Dental Treatment For Injury Only Maximum Benefit Amount:	URC, Up to $350.00 Per Tooth
Injury Caused By Motor Vehicle Maximum Benefit Amount:	URC
Prescription Drugs Maximum Benefit Amount:	URC

ACCIDENTAL DEATH, DISMEMBERMENT, LOSS OF SIGHT, SPEECH, HEARING

Principal Sum:	$20,000.00