ADL RISK SERVICES, LLC

Student Accident Form (SAF)

This form must be fully and accurately completed and submitted AS SOON AS POSSIBLE to ADL Risk Services (ADL) on or after the date of injury, and no later than 90 days from the initial date of injury, in order to avoid denial of your claims. *Please retain a copy for your records.*
Benefit eligible/covered expenses will be paid only when they are in excess of other valid and collectible insurances. ***Your medical provider must file your claim with all other available insurances prior to filing with ADL.***
Please provide all medical providers where treatment was/will be received with **ADL Risk Services'** billing address and contact information, as your secondary student accident medical insurance, to be billed directly once any applicable primary/other insurance has paid. ----------> ***IMPORTANT!** ***Please read the Accident Medical Claim Filing Instructions thoroughly and completely prior to submitting this form or filing any claims.****
***NOTE:** *In order to avoid a denial of your claim(s), please ensure the above and following criteria are met.*
Medical treatment must commence within 30 days of the initial injury date by a licensed medical doctor. (Or within 72 hours, if Emergency Room treatment is required.) Each injury has a one year (52 Week) benefit eligibility window. All claims must be filed as soon as possible, and no later than 180 days after the injury benefit period ends, or your claim(s) will be denied.
The Student Accident Plan Benefits are limited and may not provide 100% Coverage, especially if your primary insurances' annual out of pocket deductible or co-insurance requirements have not been met. This is a Student Accident Excess Benefit Plan, NOT a major medical health plan.

SUBMIT THIS FORM & CLAIMS TO:

Plan Administrator
ADL Risk Services, *LLC*
556 Clay Street
Montgomery, AL 36104
Phone: *844.350.9897*
Secure Fax: *334.649.7901*
Email: *Claims@adlrs.com*
Website: *http://adlrs.com*

PART 1: SCHOOL NOTIFICATION OF INJURY REPORT *(completed and signed by authorized school official)* Plan ID #: MS.11-11MSBASE-13

School District /Planholder: Greenville Public SD, MS		School Name:	
Name of Student (First)	(Middle:)	(Last):	
Date of Birth: _____/_____/_____	Social Security No. (last four only):	☐ Male ☐ Female	Grade:
Date of Accident/Injury _____/_____/_____ Time: _____ Place: _____	Name of Activity or Sport Type: _____	Body Part Injured: _____ ☐ Left or ☐ Right side	
At the time of the accident, was the student involved in an activity sponsored and supervised by the Planholder?		☐ Yes ☐ No	
At the time of the accident, was the student traveling to or from a regularly scheduled school activity?		☐ Yes ☐ No	
How did Injury occur?			
Name of School Official:		Was he/she a witness to the accident? ☐ Yes ☐ No	
Signature of School Representative: X_____	Title: _____	**Date:** _____/_____/_____	

Note: Part 1 above must be signed by an authorized school official, or claims will not be processed.

PART 2 : INSURANCE INFORMATION *(completed by parent/guardian)*

Is the Student covered by any other insurance Policy, either as a dependent, or under a group, individual, automobile, medical or liability Policy? ☐ Yes ☐ No

If Yes, Name of Insurance Carrier:_____ Is this ☐ Individual ☐ Group

Name of Policyholder:_____ Policy#_____

Is the above insurance a Medicaid Plan or other government insurance (such as TriCare?) ☐ Yes ☐ No

PART 3 : PARENT/GUARDIAN STATEMENT *(completed and signed by parent/guardian)*

Name of Father or Guardian (Please print legibly):		Name of Mother or Guardian (Please print legibly):	
Phone	Email	Phone	Email
Parent or Guardian Mailing Address (Include Street Address, City, State, Zip code):			
Is the above Parent/Guardian Employed? ☐ Yes ☐ No		Is the above Parent/Guardian Employed? ☐ Yes ☐ No☐	
Employer:		Employer:	

MEDICAL INFORMATION AUTHORIZATION & ASSIGNMENT OF BENEFITS: I authorize any Health Care Provider, Medical Facility, Doctor, Insurance Company or Organization to furnish at the request of ADL Risk Services, LLC or the underwriting companies with which it works, information which you may possess including, findings and treatments rendered, and copies of all hospital and medical records for professional services and hospital care rendered on my behalf. The foregoing authorization is granted with the understanding that any legal rights I may ordinarily have to claims communications between us as privileged are hereby expressly and voluntarily waived. A Photostat of this authorization shall be considered as valid and effective as the original. Payments will be made to the providers of service, unless a paid receipt/statement accompanies the medical claim submission. **Any person, who knowingly and with intent to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information, is guilty of a felony.**

SIGNATURE OF PARENT OR GUARDIAN:_____ **DATE:** _____/_____/_____