

NOTE: PLEASE READ THIS BEFORE SUBMITTING A CLAIM

INSTRUCTIONS FOR FILLING OUT THIS CLAIM FORM

NOTE: TO SCHOOL PERSONNEL AND PARENTS

Our objective at Scholastic Insurors is to provide fast and accurate claims service. Listed below are instructions that, when followed, will assist us in providing this service.

Please Note: The Accident Insurance Plan Has Exclusions and Benefit Limitations.

The Insurance Plan May Not Pay 100% For All Expenses.

WHEN TO FILE A CLAIM

1. The completed claim form and supporting documents should be sent to Scholastic Insurors within 90 days after the date of injury.

HOW TO FILE A CLAIM

1. All information on the claim form must be provided in full for us to process the claim.
2. PART A must be completed by a school official if the accident occurred during a school related activity. If the accident did not occur during a school related activity, PART A is to be completed by the parent or guardian.
3. The parent or guardian must complete PART B in full.
4. Attach *itemized* bills showing the: (a) name of patient, (b) diagnosed condition, (c) date(s) of treatment, (d) nature of treatment, and (e) charge per treatment.

WHERE TO FILE A CLAIM

Send all completed forms, itemized medical bills, etc., to:

<p>SCHOLASTIC INSURORS, INC. P. O. BOX 3194 JOHNSON CITY, TN 37602</p>

THANK YOU FOR YOUR COOPERATION

STUDENT INSURANCE CLAIM FORM

Scholastic Insurors, Inc.
P. O. Box 3194
Johnson City, TN 37602

CLAIM PROCESSING INSTRUCTIONS: Please make sure all blanks below have been fully completed.

- 1) A **school official** must complete **Part A** if the accident occurred during a school related activity. If the accident did not occur during a school related activity, **Part A** is to be completed by the **parent or guardian**.
- 2) The parent or guardian must complete **Part B**.
- 3) Attach all **itemized** medical bills (doctors, hospitals, etc.) to the claim form.
- 4) Mail completed claim form to: SCHOLASTIC INSURORS, INC., P. O. Box 3194, Johnson City, Tennessee 37602.
- 5) In the event of an accident or injury involving dental treatment, **Part C** must be completed in full by the dentist providing treatment.

THIS CLAIM CANNOT BE PROCESSED AND WILL BE RETURNED TO YOU IF COMPLETE INFORMATION IS NOT FURNISHED.

NOTE: TREATMENT MUST COMMENCE WITHIN 30 DAYS. CLAIM SHOULD BE SUBMITTED TO COMPANY WITHIN 90 DAYS FROM DATE OF ACCIDENT. ALL TREATMENT MUST BE RECEIVED WITHIN ONE YEAR OF ACCIDENT.

PART A: NOTICE OF INJURY

1. Name of School _____ Name of School System: _____
School Address _____
(city) (state) (zip)
 2. Name of Injured Student (Print) _____ Grade _____ Age _____
(first) (middle) (last)
 3. At the time of the injury, was the student involved in a school sponsored and supervised activity? ☐ yes ☐ no
 4. Date of Injury _____ Time of Injury _____
 5. Under whose supervision? _____ Title _____
 6. The accident was incurred while the student was participating in:
(check one) ☐ P. E. ☐ Game ☐ Practice ☐ Travel ☐ Other
 7. Describe the accident fully. How did the accident happen? _____

- Reported by: _____
(signature) (title) (date)

PART B: PARENT/GUARDIAN STATEMENT

1. Parent(s)/Guardian(s) Name _____ Home Phone # _____
Address _____
(Street or Route) (City) (State) (Zip)
2. I hereby authorize Reliance Standard Life Insurance Company to pay benefits, as provided by the policy, in connection with this accident to the doctor, and/or hospital rendering service unless I have checked below.
☐ I do not authorize an assignment and request benefits be paid directly to me.
3. I hereby authorize any insurance company, hospital, physician, or other person who has attended or examined the claimant to disclose when requested to do so by Reliance Standard Life Insurance Company, or its representative, any and all information with respect to any injury, policy coverages, medical history, consultation, prescription or treatment and copies of all hospital and medical records. A photo static copy of this authorization shall be considered as effective as the original.
4. I certify that I have read and understand items 1-3 (above) and I have read and understood the information of the reverse side of this form

KENTUCKY REQUIRED STATEMENT: 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.

(date)

(signature of Parent or Guardian)

ADDITIONAL INFORMATION FOR DENTAL INJURY (To be completed by dentist in the event of accident/injury involving treatment to one or more teeth. Not to be used as a replacement for a copy of the actual itemized charges.)

1. Identify injured teeth by tooth No. _____
2. Previous condition of injured teeth: _____ Whole, sound, natural; _____ Filled; _____ Decayed;
_____ Root canal treated; _____ Other (describe) _____

(Date)

(Printed Dentist's Name)

(Dentist's signature)