



STUDENT ACCIDENT REPORTING PROCEDURES INFORMATION SHEET

Dear Parents,

Your School Board continues to be vitally concerned about the health, safety and welfare of all students. We encourage safety, but we realize that sometimes student accidents do happen.

As a member of the Panhandle Area Educational Consortium-Risk Management program, the school board has purchased a student accident policy which covers all our students who are injured while in school or participating in school sponsored activities. **This insurance is accident coverage only and will not replace your current health insurance.** You need to continue such coverage for your protection.

This letter will serve as notice to you of a necessary change in the payment of expenses. We have experienced a significant increase in claims which has resulted in rising costs.

During the 2010-11 school year, **a deductible of \$100 shall be paid by the parent/guardian before any reimbursements are made from the insurance plan.**

In case of an accident, **you must file a claim with your own health insurance carrier first.** The School Board policy is designed to pay for expenses which are not reimbursed by your health insurance and after your payment of the \$100 deductible is paid to the medical provider.

This policy provides coverage only for 730 days from the date of the documented related injury. The school district and hospital are not responsible for filing a student accident claim.

In the event of an accident, the following steps must be followed:

- 1 The student must report the accident to the designated school official and obtain a Sentry Life Insurance Claim Form. The first part of the form will be completed by the school staff.
- 2 **The rest of this form must be completed by the parent/guardian and returned to Sentry Life Insurance Company within 90 days of the date you received medical treatment.**
- 3 If you have additional expenses after the initial claim is filed, submit the bills directly to Sentry Life Insurance Company and not to the school. Be sure to mail them within 90 days of the date of treatment.
- 4 Parents please keep a copy of all medical statements and billing notices for your records.

Give Sentry Life Insurance a reasonable amount of time to process your child's claim. If you have not heard from the insurance company or continue to get repeat bills, check on the status of a claim by calling Sentry direct at 1-800-426-7234 or write:

Stevens Point Policy Benefits
P.O. Box 8025 Stevens Point,
Wisconsin 54481

CLAIM FORM
ORIGINAL SIGNED CLAIM FORM IS REQUIRED



SENTRY
LIFE INSURANCE
COMPANY

MAIL ALL CORRESPONDENCE TO:
Stevens Point Policy Benefits
P.O. Box 8025
Stevens Point, WI 54481
1-800-426-7234 Toll-Free

IMPORTANT NOTICE

Your student insurance plan is designed to provide maximum benefits for minimum premium. This plan of insurance is secondary to any health insurance you have. If you have other insurance, submit your claim to your other insurer. When you receive their Benefit Statement, send it to us along with your itemized bills, with diagnosis, and this completed form. **SEE REVERSE SIDE FOR ADDITIONAL INSTRUCTIONS ON FILING A CLAIM**

TO BE COMPLETED BY THE ORGANIZATION/SCHOOL

Policy Number: _____

Organization/School Name: _____

Address: _____ Phone No. (____) _____

_____ Type of Activity: _____

If Athletics, designate: P.E. Class Intramural Interscholastic Practice Game Jr. Varsity Varsity

At the time of Injury, was the student involved in a school sponsored and supervised activity? Yes No

Under whose supervision? _____ Was he/she a witness? Yes No

Date of Accident: _____ Time: _____

Where & How did Accident occur? (Please be specific) _____

Part of body injured: _____ Date of first treatment: _____

Signature: **X** _____ Title: _____ Date: _____

(MUST BE SIGNED BY AN ORGANIZATION/SCHOOL OFFICIAL UNLESS INJURY DID NOT OCCUR DURING ORGANIZATION/SCHOOL ACTIVITY. ORIGINAL SIGNATURE IS REQUIRED.)

TO BE COMPLETED BY CLAIMANT – OR BY PARENT/LEGAL GUARDIAN IF CLAIMANT IS A MINOR

Claimants Name: _____

Date of Birth: _____ Age: _____ Grade Level: _____ Male Female

Address of Parents
Guardian or Claimant: _____

_____ Phone No. (____) _____

Name and address of Family Physician: _____

Phone No. (____) _____ Has treatment been completed? Yes No

Father/Guardian Name: _____

Employer Name & Address: _____

_____ Phone No. (____) _____

Mother/Guardian Name: _____

Employer Name & Address: _____

_____ Phone No. (____) _____

PLEASE CONTINUE TO BACK OF THE FORM WHICH MUST BE COMPLETED

Name of all companies providing your insurance coverage or prepaid health plans:

Name of Company

Address

Policy #

PLEASE CHECK BOX

Individual Group
Self-Funded No Insurance
Other (Any Valid & Collectible Insurance)

Are benefits due for this claim under these other insurance coverages? Yes No
(See IMPORTANT NOTICE at top of form reverse side)

I verify that the above statement on other insurance is accurate and complete. I understand that the intentional furnishing of incorrect information via the U.S. Mail may be fraudulent and violate federal laws as well as state laws. I agree that if it is determined at a later date that there are other insurance benefits collectible on this claim I will reimburse Sentry Life Insurance Company to the extent for which Sentry Life Insurance Company would not have been liable.

Signature: _____ **Date:** _____

ORIGINAL SIGNATURE IS REQUIRED

OPTIONAL AUTHORIZATION TO RELEASE INFORMATION:

I hereby authorize Sentry Insurance to discuss any information related to medical expenses incurred or treatments rendered in connection with this claim, with Special Markets Insurance Consultants, Inc. representatives and their assigned agents and to officials at the school or organization through which this policy is issued. A photo static copy of this authorization shall be considered as effective and valid as the original.

Signature: _____ **Date:** _____

Claimant if age 18 or over, parent or guardian for claimant under 18

SEVERAL STATES REQUIRE THE FOLLOWING STATEMENT TO APPEAR ON THIS FORM:

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 INFORMATION CONCERNING ANY MATERIAL FACT FOR THE PURPOSE OF MISLEADING, COULD BE GUILTY OF INSURANCE FRAUD WHICH MAY BE A CRIME. THIS DOES NOT APPLY TO VIRGINIA RESIDENTS.

OKLAHOMA: 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.

PLEASE FOLLOW THESE INSTRUCTIONS TO FILE A CLAIM

- ❖ Obtain claim form from your school office or the marketing agent and answer all questions in detail (including all signatures on the front of the form). A claim form needs to be completed for each accident.
- ❖ If you have other insurance, submit your claim to your other insurer. When you receive the **EXPLANATION OF BENEFITS NOTICE FROM YOUR PRIMARY CARRIER**, send it to us along with the corresponding **ITEMIZED BILLS** with diagnosis along with this fully completed claim form. **KEEP COPIES OF ALL CLAIM FORMS, BILLS AND CORRESPONDENCE FOR YOUR OWN RECORDS UNTIL YOUR CLAIM HAS BEEN PROCESSED.**
- ❖ If you already paid the bill, include a paid receipt or a copy of your cancelled check. Otherwise payment will be made to the providers of service (Hospital, Physician or Others), unless a paid receipt statement accompanies the bill at the time the claim is submitted.
- ❖ Mail all correspondence to Stevens Point Policy Benefits, P.O. Box 8025, Stevens Point, WI 54481. The claim form must be sent within 90 days of the date you first received medical care. Any bills not filed with the claim form should be sent, within 90 days of the date you received medical care, to the Company identified with student's name, school district and date of Accident.
- ❖ If you change your address, please notify Sentry Life Insurance Company by calling 1-800-426-7234 so that there is no delay in processing any claims.
- ❖ Please contact Sentry Life Insurance Company by calling 1-800-426-7234 if you would like to check the status of your claim or if you have any questions on how your claim was processed or the benefit paid.