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## NOTIFICATION OF INJURY

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This Notification of Injury Form is to be used for accident medical claims.

### **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.

### **Deductible**

If the claimant is paying the deductible prior to submitting any claims for adjudication, please complete the back of this form. This will ensure we will be able to credit the appropriate charges to the deductible. Please be aware, although every effort will be made to match your requests, charges that have been reduced due to discounts, reasonable and customary guidelines, or plan maximums may not be credited towards the deductible.

### **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?* \_\_\_\_\_

*If claim has first been submitted to the primary health insurance company, are copies of EOB's (explanation of benefits) attached?* \_\_\_\_\_

*Is part (A) of the claim form completed by the Policyholder official or staff member and signed?* \_\_\_\_\_

*Is part (B) of the claim form completed by the injured person and signed?* \_\_\_\_\_

*Are the attached medical bills itemized in either a CMS 1500 or UB04 form?* \_\_\_\_\_

*Is part (B), item number 3 (social security number) completed?* \_\_\_\_\_

**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  
PO 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) 373-9707, Attn: Supplemental Accident. Please do not fax full medical claims, as often times medical bills are illegible when faxed.

**PLEASE NOTE, claim forms should NOT be submitted prior to claims being incurred. Please submit the claim form at the time the itemized bills and explanations of benefits are available for reimbursement.**

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**ACCIDENT DEDUCTIBLE CREDIT SHEET**

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INJURED'S NAME: \_\_\_\_\_

POLICYHOLDER'S NAME: \_\_\_\_\_

DATE OF INJURY: \_\_\_\_\_

NAME & ADDRESS CHECK SHOULD BE SENT TO:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PROVIDER	DATE OF SERVICE	\$ AMOUNT APPLIED TO DEDUCTIBLE
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____

*If the claimant is paying the deductible prior to submitting any claims for adjudication, please complete this form. This will ensure we will be able to credit the appropriate charges to the deductible. Please be aware, although every effort will be made to match your request, charges that have been reduced due to discounts, reasonable and customary guidelines, or plan maximums may not be credited towards the deductible.*



**NOTICE**

**WARNING: FOR RESIDENTS OF ALL STATES OTHER THAN THOSE LISTED AT THE BACK OF THIS FORM:** Any person who knowingly, and with intent to defraud, injure or deceive any insurance company, files or causes to be filed, a claim for payment of a loss, containing any false or incomplete information commits a fraudulent insurance act that may be a crime and may subject such person to confinement in prison, fines and denial of benefits.

<b>PART A – This PART MUST be completed, dated and signed by an official or the Organization.</b>			
1. Name of Organization (Policyholder)			
2. Policy No.			
3. Name of Organization or Team (if different from Policyholder)			
4. Address of Organization (Street)		4. Address of Organization (City) (State) (Zip)	
5. Name of Injured Person (Insured) (First)		5. Name of Injured Person (Insured) (Middle) (Last)	
6. Date of Accident/Injury Mo      Day      Year /      /		7. Injury Occurred: Practice <input type="checkbox"/> Travel <input type="checkbox"/> Game <input type="checkbox"/> Other _____	
8. Type of Sport or Activity:			
9. Explain HOW the accident and injury occurred. NOTE: If your organization uses an Accident Report form, attach a copy of the Report.			
10. Describe the nature of injury.			
11. At the time of the accident, was the Injured Person involved in an activity under the jurisdiction of the Organization (Policyholder)? Yes <input type="checkbox"/> No <input type="checkbox"/>		12. Name of Supervisor of Activity	
		13. Was he/she a witness to Yes <input type="checkbox"/> No <input type="checkbox"/>	
14. Signature of Organization Official <b>X</b> _____		15. Title of Official	
		16. Area Code/Telephone No. (    )	
		17. Date Signed	
<b>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.</b>			
PRINT HERE – NAME OF PERSON COMPLETING FORM		Check one: Injured Person <input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/>	
Give the following information about the Injured Person:			
1. Date of Birth Mo      Day      Year /      /		2. Male <input type="checkbox"/> Female <input type="checkbox"/>	
		3. Social Security No. or Student Visa No. /      /	
		4. Area Code/Telephone No. (    )	

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

Name of Father or Male Guardian	Social Security No. / /
Place of Employment	
Address of Employer	Area Code/Employer Phone No. ( )

Name of Mother or Female Guardian	Social Security No. / /
Place of Employment	
Address of Employer	Area Code/Employer Phone No. ( )

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

Name of Father or Male Guardian	Social Security No. / /
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 Berkley Group Companies: StarNet Insurance Company, Acadia Insurance Company, Berkley Life and Health 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 24 months from the date shown below. I understand that my authorized representative or I will receive a copy of this authorization upon request.

**NEW YORK:** 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

**X** \_\_\_\_\_  
 Signature (in writing) of Responsible Party

\_\_\_\_\_  
 Print Name

Check one:  Injured Person  
 Parent  
 Guardian

Date: \_\_\_\_\_

**ARIZONA:** 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 :** 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:** 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.

**DISTRICT OF COLUMBIA:** WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

**FLORIDA:** WARNING: 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.

**INDIANA:** A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

**KENTUCKY:** 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.

**MINNESOTA:** A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

**NEVADA:** Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under state or federal law, or both, and may be subject to civil penalties.

**NEW JERSEY:** Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

**OHIO:** 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.

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

**OREGON:** Any person who knowingly and with intent to defraud or solicit another to defraud an insurer: (1) by submitting an application, or (2) by filing a claim containing a false statement as to any material fact, may be violating state law.

**PENNSYLVANIA:** 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.

**VIRGINIA:** Please NOTE that these fraud warnings **DO NOT** apply in the State of Virginia.