

**ENROLL ONLINE NOW at www.k12studentinsurance.com
K-12 STUDENT ACCIDENT INSURANCE PLANS**

How to Enroll

Enrolling online is easy & takes only a few minutes. Go to www.k12studentinsurance.com

1. **Browse** the available Plans and Rates.
2. **Pick your State** -see if your School is available.
3. **Open New Account** - Once you have determined your school is covered, you'll need to open a new account for this school year (you must create a new account each school year).
If you have created your account for this year, please remember your **User ID and Password**.
4. **Add Student & Coverage** by clicking on the "Add Student" button on top of page.
Continue to add each student by clicking on the "Add Student" button until all your students are added.
5. Select "**Checkout**".
6. Select your **payment type** and click "Continue Checkout".
7. Enter **billing information** and click "Continue Checkout".
8. Click "Pay and View Receipt" to **complete your order**.
9. **Coverage** is effective when payment is "**Confirmed**". **Effective Date** will be shown on your **ID CARD**.
10. **Save your receipt** for future reference.

If you have questions, please call us at **1-888-574-6288**.

Accident coverage underwritten by QBE INSURANCE CORPORATION

Inscribase ahora en www.k12studentinsurance.com

K-12 PLANES DE COBERTURA DE ACCIDENTES DE SEGURO PARA ESTUDIANTES

COMO INSCRIBIRSE

Inscribirse en linea, es tan censillo, y solamente toma unos minutos.

Por favor entre a la pagina www.k12studentinsurance.com

1. **Revise** los planes y las tarifas disponibles.
2. Elija su Estado y confirme que su escuela este disponible por el año escolar en curso
3. **Abrir una Nueva Cuenta-** Una vez que haya verificado que su escuela ofrece cobertura, devera abrir una nueva cuenta para el año escolar en curso. (Devera crear una nueva cuenta cada año escolar). Si ya ha creado su cuenta para el año en curso...**recuerde su identificacion de usuario y la contraseña.**
4. Agregue el nombre del estudiante y la cobertura, oprimiendo el boton “add student” al final de la pagina. *Continue agregando los nombres por cada estudiante, hasta terminar con todos los nombres necesarios.*
5. Seleccione el boton de “**checkout**”
6. Seleccione su forma de pago oprimiendo el boton “**continue checkout**” al final de la pagina para continuar con el pago
7. Llene la dirección a donde recibe su correspondencia y oprima el boton “**continue checkout**” al finial de la pagina.
8. Para continuar con su orden, oprima el boton “**Pay and View Receipt**”.
9. La cobertura comienza cuando el pago sea “**Confirmado**”. La fecha aparecerá en la tarjeta de **identificación**.
10. Guarde su recivo como **referencia**, por si lo necesita en el futuro.

Si tiene preguntas por favor llámenos al: 1 888-574-6288.

Cobertura de accidente suscrita por QBE Insurance Corporation



School District:
Charlton County

School Name:

STUDENT CLAIM FORM

- 1. Please fully complete this form
2. Attach itemized bills
3. E-mail, Fax or Mail to HSR

E-mail : K12claims@hsri.com
Fax: (972) 512-5818

P.O. Box 117558
Carrollton, Texas 75011-7558
Phone: (972) 512-5600 Toll Free (866) 409-5734

Policy Number:

District Paid / Voluntary / CAT
N/A / SHH030004 / N/A

District Paid __ Voluntary _X_ CAT __

PART I - POLICYHOLDER'S REPORT

Form with fields for: 1. Claimant's Name, 2. Social Security Number, 3. Gender, 4. Date of Birth, 5. E-Mail, 6. Address of Injured Person, 7. Phone Number, 8. Parent/Legal Guardian Name, 9. Phone Number, 10. Date of Accident/Illness, 11. Time of Accident, 12. Place where Accident Occurred, 13. Date of First Treatment, 14. Indicate which Teeth were Involved in the Accident, 15. Describe Condition of Injured Teeth Prior to Accident, 16. Type of Injury, 17. Describe How Accident Occurred, 18. Which Best Describes the Activity, 19. Name of Person Supervising the Activity, 20. Type of Activity or Sport, Signature of Parent/Legal Guardian, Signature of School Official.

PART II - OTHER INSURANCE STATEMENT

Do you/spouse/parent have medical/health care or is the Claimant enrolled as an individual, employee or dependent member of a Health Maintenance Organization (HMO) or similar prepaid health care plan, or any other type of accident/health/sickness plan coverage through your employer or other source on you or, if applicable, does your son/daughter have health care coverage as a dependent from your previous marriage as mandated in a divorce decree? Yes No

Form with fields for: If Yes, name of insurance company, Policy #, Name of insurance company, Policy #, If applicable, claimant's primary employer name, address, and phone number, If applicable, mother's primary employer name, address, and phone number, If applicable, father's primary employer name, address, and phone number.

IF OTHER INSURANCE OR HEALTH CARE PLANS EXIST, PLEASE SUBMIT COPIES of their EXPLANATION OF BENEFITS along with your claim. IF NO OTHER INSURANCE OR HEALTH PLAN EXISTS, PLEASE READ & SIGN BELOW.

I agree that should it be determined at a later date there is insurance (or similar), to reimburse HEALTH SPECIAL RISK, INC., or the insurance company to the extent of any amount collectible.

Form with fields for: Signature of Parent/Legal Guardian, Date, Signature of Witness, Date.

PART III - AUTHORIZATION TO PAY BENEFITS TO PROVIDER

I hereby authorize medical payments to be made directly to doctor(s), hospital(s), or indicated provider(s) of service(s) in connection with this claim. (If not signed submit proof of payment)

SIGNATURE DATE

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, all information with respect to any injury, policy coverage, medical history, consultation, prescription or treatment, and copies of all hospital or medical records. A photo static copy of this authorization shall be considered as effective and valid as the original.

SIGNATURE

DATE

FRAUD STATEMENTS

FOR RESIDENTS OF ALL STATES OTHER THAN THOSE LISTED BELOW:

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Alaska and 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, incomplete or misleading information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and may be prosecuted under state law.

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.

Arkansas, Louisiana, Maryland, West Virginia & Rhode Island: Warning: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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.

Connecticut: This form must be completed in its entirety. Any person who intentionally misrepresents or intentionally fails to disclose any material fact related to a claimed injury may be guilty of a felony.

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

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.

Hawaii: 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.

Georgia: Any natural person who knowingly or willfully

1) Makes or aids in the making of any false or fraudulent statement or representation of any material fact or thing:

- a) In any written statement;
- b) In the filing of a claim; or
- c) In the receiving of money for an application for a policy of insurance for the purpose of procuring or attempting to procure the payment of any false or fraudulent claim or other benefit by an insurer;

2) Receives money for the purpose of purchasing insurance and converts such money to such persons own benefit;

3) Issues fake or counterfeit insurance policies, certificates of insurance, insurance identification cards, or insurance binders; or

4) Makes any false or fraudulent representation as to the death or disability of a policy or certificate holder in any written statement for the purpose of fraudulently obtaining money or benefit from an insurer commits the crime of insurance fraud.

Maine: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or a denial of insurance benefits.

Michigan, North Dakota, South Dakota: Any person who knowingly and with intent to defraud any insurance company or another 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, and subjects the person to criminal and civil penalties.

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 Hampshire: Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

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

New Mexico and 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.

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.

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 any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Oregon: Warning: Any person who knowingly, and with intent to defraud any insurance company or other persons 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, may be subject to prosecution for insurance fraud.

Tennessee, Virginia, Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Texas: 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.

Listed below are important instructions and comments about filing a claim.

Note: Benefit Period is 52 weeks from date of accident

YOUR CLAIM FORM

1. This claim form should be fully completed and submitted within 90 days from the date of injury. Be sure to answer and complete the section regarding “**OTHER INSURANCE STATEMENT**”, marking either yes or no, and signing the line for authorization, so that **HSR** and the doctors/hospital may communicate concerning your claim.

Incomplete claim forms are one of the most frequent reasons why claim payments are delayed.

2. Only one claim form for each accident needs to be submitted.
3. Once completed, E-mail, Fax or make a photocopy for your records, and mail to the address shown below.
4. DO NOT assume that anyone else will mail this claim form to **HSR** for you.

YOUR BILLS

1. Please advise all doctors/hospitals regarding this coverage so they may forward us their itemized bills.
2. If you have already been to the doctor/hospital and did not know about this coverage, then please send all of the itemized bills to **HSR** at the address shown below.
3. The bills should include the name of the doctor/hospital, their complete mailing address, telephone number, the date you were seen by the doctor/hospital, what the doctor saw you for (diagnosis) and the specific itemized charges (description of treatment and amount) incurred (including the CPT/procedure code).
4. If this information is not on the bill when you send this in we will have to contact the doctor/hospital which will delay the review of your claim. “Balance Due” or “Balance Forward” statements do not contain sufficient information to complete your claim.

EXCESS INSURANCE

1. This policy provides coverage on a secondary/excess basis. If you have any other primary insurance coverage you need to send the bills to your primary insurance first.
2. **HSR** will consider benefits after your other, primary insurance has processed the claim.
3. We will require a copy of your primary insurance Explanation of Benefits (EOB) which you should receive from your primary insurance letting you know what was paid or denied, and the reason(s) why.
4. **HSR** will not be able to consider your claim without this information.

If you have any questions, please contact Customer Service at (866) 409-5734. They are available from 8:00 a.m. thru 6:00 p.m. central time, Monday – Friday. You may also forward any documents by fax to (972) 512-5818.

Health Special Risk, Inc.

E-mail : K12claims@hsri.com

Fax: (972) 512-5818

P.O. Box 117558

Carrollton, Texas 75011-7558

Phone: (972) 512-5600 Toll Free (866) 409-5734