KidGuard CLAIM FORM

CLAIM FORM AND NOTICE OF INJURY TO BE MAILED TO:
KidGuard, P.O. BOX 784268, WINTER GARDEN, FLA. 34778-4268

The underwriting insurance company is Reliance Standard Life Insurance Co. Schaumburg, IL.

PARENTS: Policy limitations and exclusions are on the take home summary of insurance brochure. The Policy does not pay 100% of billed expense. It is the parent/guardian's responsibility to ask Doctors and Providers what remaining balances you may be required to pay regarding this claim, if any. This is ***'Excess Insurance***'. **Y**ou MUST file a claim with your primary insurance first. A school Official is required to fill out PART B only if the injury is school related. This form cannot be processed unless all questions are answered below and all signatures are in place. It is the duty of the claimant,(Parent/Legal Guardian), to furnish the company with itemized bills, explanation of primary insurance benefits paid, and this form completed. Visit KidGuard.com for information regarding where to seek treatment and claim filing instructions. THIS CLAIM FORM MUST BE FILED WITHIN 90 DAYS AFTER DATE OF ACCIDENT. The policy allows for bills to be sent in for up to one year from the date of accident. **PLEASE DO NOT LEAVE THIS FORM WITH YOUR PHYSICIAN OR HOSPITAL.** It is the parent/guardian's responsibility to ask Doctors/ Providers what remaining balances you may be required to pay regarding this claim, if any.

PART A: PARENT/GUARDIAN MUST COMPLETE AND SIGN PART A. Please print your answers.

1. Name of School: County: Grade:

2. Last Name of Student: First Name: Middle Initial:

3. Mailing Address of Parent: City: State: Zip:

4. Home Phone # ( ) - Date of Birth / /

5) **WE CANNOT PROCESS THIS CLAIM UNLESS YOU GIVE US A DETAILED DESCRIPTION OF HOW, WHEN AND WHAT OCCURRED, THAT CAUSED THE INJURY. (Use back of this form if more space is needed).** How? What? When? Be specific please.

6. **INJURY DATE:** Month Day Year Time AM ◉ PM ○ Where did the accident happen?

If this is sports related what is the name of the team or camp?

7. Nature of Injury or sickness (indicate part of body injured-such as broken arm, sprained ankle etc…)

8. **NAME OF ANY OTHER INSURANCE** that may provide benefits for this injury. (If none, say none. Do not leave this line blank).
Other insurance includes but is not limited to the following: HMO's, PPO's BC/BS, United, Employer Benefits, ERISA, Medicaid, Welfare or Government Trust accounts, or Tri-care. **It is the parent/guardian's responsibility to ask Doctors and Providers what remaining balances you may be required to pay regarding this claim, if any. This policy will not pay for 100% of billed charges.** What is deductible or co-pay (if any)? $

If you have a Medicaid plan please send a copy of your insurance card with this form.

9. Address of claims office of insurance company on line 8.

10. Mother's Name and Employer: Occupation:

Mother's Employer Address: Telephone #

11. Father's Name and Employer: Occupation:

Father's Employer Address: Telephone #

****The above answers are true and correct. I hereby authorize any person or institution to release any information requested by the insurance company or its agent to them, including history and physical, diagnosis or other medical or insurance information. A photo static copy of this authorization shall be considered as effective and valid as the original. **FLORIDA LAW:** "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 of third degree."*

12. PARENT/GUARDIAN SIGN HERE: Today's Date: / / Print Name:

PART B - Must be filled out and signed by a School Official for ALL school sports related injuries. Must be filled out for all other school related injuries unless the student purchased the 24 Hour Plan.

1. WE CANNOT PROCESS THIS CLAIM UNLESS YOU GIVE US A DETAILED DESCRIPTION OF HOW THE ACCIDENT OCURRED THAT CAUSED THE INJURY. Please be specific. (Use back of this form if more space is needed.)

2. Injury Date: Month Day Year Time AM ○ or PM ○ Part of body injured (include whether right or left)

3. At the time of the injury was the student involved in a school sponsored, funded, scheduled and supervised activity? YES ○ NO ○

Please select or list the interscholastic sport or activity the student was participating in. Circle One.

P.E. Class - Football Game - Football Practice - Soccer - Volleyball - Baseball - Softball - Track - Wrestling - Flag Football - Competitive Cheerleading - Rugby Lacrosse-- Side line Cheerleading - Basketball OTHER LIST

4. Under whose supervision(witness)? What date has the Athlete returned to play if applicable? / /

5. Print Name of School Official School phone Number: - -

6. **Original Signature of School Official** (Only if injury is School Related) Today's Date: / /

Please DO NOT LEAVE THIS FORM with the Doctor or Hospital. Mail to KidGuard immediately upon completion.

PART C: ATTENDING PHYSICIAN OR DENTIST STATEMENT. Itemized bills are required to determine the eligibility of a claim. **If the provider is going to bill us directly you do NOT need to have PART C completed.**

1. Diagnosis and Concurrent conditions. Explain any complications._____

2. Date you first treated the sickness or injury____/____/_____ Dates of subsequent treatment: _____

3. When did the symptoms first appear? Date: _____

4. Were your services necessary solely because of the incident described in part A(front)? YES ◯ NO ◯ Is treatment completed? YES ◯ NO ◯

5. Did any previous injury, sickness or impairment contribute to this injury? YES ◯ NO ◯ If yes, explain details._____

_____

6. Did x-ray show fracture? YES NO If fracture or dislocation, state whether reduced or immobilized and what the procedure was?

_____CPT/CRVS_____

7. Physician's Degree (M.D.,etc.)_____Print name of physician or dentist: _____

8. Federal tax ID# (or Soc. Sec. #) _____**(Benefits cannot be paid to you without this).**

9. Address of physician or dentist. STREET NUMBER_____

CITY_____STATE_____ZIP CODE_____***Signature of physician or dentist***: _____

10. FOR DENTAL CLAIMS ONLY: Indicate which teeth were involved in the accident? _____
11. Describe condition of injured teeth prior to accident: **Circle conditions:**
Filled--- Capped--- Artificial--- chipped--- broken--- crowned- damaged--- abscessed---Otherwise Fitted--- Whole, sound and natural--- Other_____

PLEASE FOLLOW THESE INSTRUCTIONS TO FILE A CLAIM

1) You must file your claim with your other (Primary) insurance company first. Other insurance include, but not limited to: HMO's, PPO's BC/BS, United, Employer Benefits, HSA's or Tri-care***. This is secondary coverage*** and may not pay for 100% of medical expenses incurred. When your claim has been processed by your primary insurance; mail a copy of the explanation of benefits (EOB's), the itemized bills to *KidGuard.* **We cannot accept a balance due statement, itemized bills are required.** ***Important note***: **Please do not leave the claim form with the Hospital or Doctor's Office.** Participants can seek treatment from any licensed provider of service. **It is the participants responsibility to find out what out of pocket expenses they could incur. Please ask your provider of service if they are in your primary network. Visit KidGuard .Com for provider information.**

2) **A completed KidGuard Claim Form must be submitted within *90 days* from the date of the incident**. If the condition is school related or happened at school Part B must be completed. If the condition did not happen at school complete Part A and mail directly to KidGuard for additional information please contact KidGuard 1-800-432-6915.

3) The plan administrator mailing address is: **KidGuard**

P.O Box 784268
Winter Garden, FL. 34778-4268

Reasons claims are delayed for processing: **1**. Claim Forms Not Completed In Full or Not Submitted. **2**. Balance Due Statements, Balance Forward Statements, or Past Due Statements submitted instead of the correct Medical Itemized Bills (UB-04/92 or HCFA-1500) which are standard forms used by providers of service or Doctors. **3**. Explanation of Benefits from Primary Insurance Carrier not provided with the correct bills.

If we do not receive your reply within 45 days, we will close our file. However, upon receipt of the requested information, we will reopen the file and process your claim in accordance with the policy provisions.

ADDITIONAL
COMMENTS:_____

_____

_____

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FRAUD NOTICE STATEMENTS

NOTICE TO APPLICANTS: "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 MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES."

RESIDENTS OF ARKANSAS APPLICANTS: "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."

RESIDENTS OF COLORADO APPLICANTS: "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."

RESIDENTS OF FLORIDA APPLICANTS: "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."

RESIDENTS OF KANSAS APPLICANTS: "ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON CAUSES TO BE PRESENTED OR PREPARES WITH KNOWLEDGE OR BELIEF THAT IT WILL BE PRESENTED TO OR BY AN INSURER, PURPORTED INSURER, BROKER OR ANY AGENT THEREOF, ANY WRITTEN STATEMENT AS PART OF, OR IN SUPPORT OF, AN APPLICATION FOR THE ISSUANCE OF, OR THE RATING OF AN INSURANCE POLICY, OR A CLAIM FOR PAYMENT OR OTHER BENEFIT PURSUANT TO AN INSURANCE POLICY WHICH SUCH PERSON KNOWS TO CONTAIN MATERIALLY FALSE INFORMATION CONCERNING ANY FACT MATERIAL THERETO, OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT WHICH IS A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES."

RESIDENTS OF KENTUCKY APPLICANTS: "ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE 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."

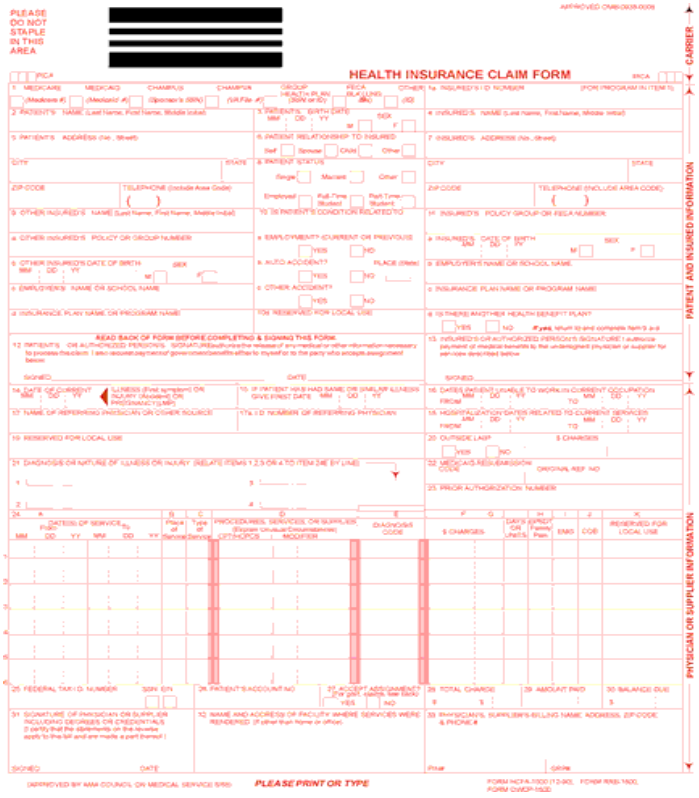
RESIDENTS OF OHIO APPLICANTS: "ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE/SHE IS FACILITATING A FRAUD AGAINST ANY INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD."

RESIDENTS OF TENNESSEE APPLICANTS: "IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS."

RESIDENTS OF VIRGINIA APPLICANTS: "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 AND DENIAL OF INSURANCE BENEFITS."

This is a sample of an itemized bill. Balance due statements or summary of accounts are not itemized bills. Please submit itemized bills so we may promptly review claims.

SAMPLE HCFA 1500



SAMPLE UB-04

SAMPLE EOB (EXPLANATION OF BENEFITS)