PROOF OF CLAIM

This form should be completed and submitted to the Company within 90 days from date of injury.

Mail completed form to:
STUDENT ASSURANCE SERVICES, INC.
P.O. BOX 196
STILLWATER, MINNESOTA 55082

***NOTICE:** Anyone who knowingly misrepresents or falsifies essential information requested by this form may upon conviction be subject to fine or imprisonment.*

CLAIM PROCEDURE:

1. A school official must complete PART A*.
2. The Insured's parents or guardian must complete PART B.
3. If dental charges — have statement completed on back.
4. See reverse side for important claim procedures.

TO BE COMPLETED BY A SCHOOL OFFICIAL

PART A: NOTICE OF INJURY

1. Name of School _____ School District Name _____
   School Address _____ (City) (State) (Zip)
2. Name of Insured _____ Grade _____
3. Date of Injury _____ ☐AM ☐PM
4. Under whose supervision? _____ Was he/she a witness? _____
5. The accident was incurred while the Insured was participating in:

INTERSCHOLASTIC SPORTS		NON-INTERSCHOLASTIC SPORTS	
( ) Practice	What sport?	( ) Travel to/from school	( ) Non-school activity
( ) Game		( ) In classroom	( ) Other – Activity?
( ) Travel	_____	( ) Physical Education	_____
		( ) On school grounds	

6. Part of the body injured _____ ☐R ☐L
7. Describe in detail how and where the injury occurred _____

_____

_____

_____

Reported by _____
(Signature of School Official) (Title) (Date)

(*Part A may be completed by the parent if Full-Time Coverage was purchased.)
IMPORTANT INFORMATION ON REVERSE SIDE

TO BE COMPLETED BY A PARENT OR GUARDIAN

PART B: PARENT STATEMENT

1. Students Name _____ Birthdate _____
   Students Social Security # ☐☐☐-☐☐-☐☐☐☐
   Parents Name _____ Relationship to Insured _____
   Address _____
   (Street or Route) (City) (State) (Zip)
2. Home phone number _____
3. Father's Occupation _____ Employer _____
   Mother's Occupation _____ Employer _____
4. List your family or group coverage, please.
   Name of Insurance Company _____ ☐Group ☐Individual ☐PolicyNo. _____
   Address _____
   (Street) (City) (State) (Zip)

I hereby authorize any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance company, or other organization, institution, or person that has any records or knowledge of the claimant's physical or mental health, to give the information to STUDENT ASSURANCE SERVICES, INC. To facilitate rapid submission of such information, I authorize all said sources, to give such records or knowledge to any agency employed by the insurance company to collect and transmit such information. A photocopy of this authorization shall be as valid as the original. This authorization expires one year from the date signed.

_____ (Date) _____ (Print Name of Student/Patient) _____ (Signature of Parent or Guardian)

TO: Parent or Guardian

STEPS TO FOLLOW WHEN FILING A CLAIM:

1. A school official **must** complete Part A for all school related accidents. The parent or guardian must complete **all** questions in Part B – Parent Statement. If the accident is not school related, parent or guardian **may** complete Part A. **Do NOT leave this Claim Form with the physician or hospital. Complete and submit directly to the Claim's Office at the address indicated below.**

2. Send copies of **itemized bills**. These are the original billings you receive, not monthly statements. **These itemized bills often called UB92 or HCFA 1500 provide the Address, Procedure Code, Diagnosis Code, and the Provider's Tax ID Number.**

3. Submit copies of all bills to your family and/or group insurance, even if you have a large deductible. This plan is supplemental to all other valid coverage. You must file a claim with your other insurance first. This plan does not cover penalties imposed for failure to use providers preferred or designated by your primary coverage. After you have received payment or copies of "Explanation of Benefits" (EOB) from your family insurance company or insurance administrator (Blue Cross, Group Health, Prudential Insurance, etc.), **send our claim form, copies of itemized bills and your other insurance E.O.B.'s to:**

STUDENT ASSURANCE SERVICES, INC.
P.O. BOX 196
STILLWATER, MN 55082-0196

NO CLAIM CAN BE PROCESSED UNTIL ALL OF THE ABOVE DOCUMENTS ARE PROVIDED.

PLEASE REFER TO THE MASTER POLICY ISSUED TO THE SCHOOL/SCHOOL DISTRICT FOR SPECIFIC DETAILS.

ATTENDING DENTIST'S STATEMENT

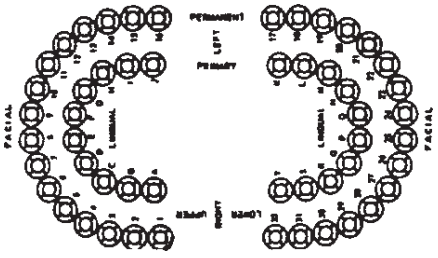
(1) DATE OF ACCIDENT

(2) IF PROTHESIS, IS THIS INITIAL PLACEMENT? ☐ YES ☐ NO

(3) WERE THE TEETH SOUND OR NATURAL PRIOR TO THE CURRENT TREATMENT? ☐ YES ☐ NO

(4) ARE ANY SERVICES COVERED BY ANOTHER PLAN? IF SO, NAME PLAN ☐ YES ☐ NO

IDENTIFY ALL TEETH WITH AN "X" THAT WERE INVOLVED IN THIS ACCIDENT



TOOTH NO.	DESCRIPTION OF SERVICE	DATE OF SERVICE	FEE
		TOTAL FEE	

DENTIST'S NAME

X
SIGNATURE DEGREE

STREET ADDRESS

DATE

CITY STATE ZIP

( ) TELEPHONE

Federal ID Number — No benefits can be paid until we have your ID number.