STUDENT CLAIM FORM

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

P.O. Box 117558
Carrollton, Texas 75011-7558
Phone: (972) 512-5600 Fax: (972) 512-5818
Toll Free (866) 409-5734
E-mail : K12claims@hsri.com

School District:

School Name:

Student ID Number:

PART I – POLICYHOLDER'S REPORT

1. Claimant's Name (injured/ill person)	2. Social Security Number	3. Gender ☐ M ☐ F	4. Date of Birth	5. E-Mail

6. Address of Injured Person	7. Phone Number (include area code)
8. Parent/Legal Guardian Name, Address, City, State & Zip	9. Phone Number (include area code)

10. Date of Accident/Illness	11. Time of Accident ☐ a.m. ☐ p.m.	12. Place where Accident Occurred (include city& state)	13. Date of First Treatment

Dental Claims	14. Indicate which Teeth were Involved in the Accident	15. Describe Condition of Injured Teeth Prior to Accident: ☐ Whole, Sound, and Natural ☐ Filled ☐ Capped ☐ Artificial

16. Type of Injury (Indicate Part of Body Injured – e.g. broken arm, sprained ankle, etc.) Did Injury Result in Death? ☐Yes ☐No

17. Describe How Accident Occurred or the Nature of the Illness – Give all possible details

18. Which Best Describes the Activity:

- ☐ Play or practice of interscholastic sports
- ☐ Not school related
- ☐ P.E. class
- ☐ During lunch hour
- ☐ In school bus
- ☐ School sponsored field trip
- ☐ Traveling to/from school
- ☐ Athletic period
- ☐ On school property during school hours
- ☐ School sponsored activity during school hours
- ☐ ROTC activity

19. Name of Person Supervising the Activity	20. If engaged in an Interscholastic Sport at the time of the injury, what was the sport?

Signature of Parent/Legal Guardian: X Date:	Signature of School Official: X Date:

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

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.

Signature of Parent/Legal Guardian: X Date:	Signature of Witness: X 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.

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, 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.
P.O. Box 117558
Carrollton, TX 75011-7558

Dear [USER]:

You are currently registered as an active user of the ***HSR*** **K12 Fast Track** (**http://www.hsri.com/K12FT**) website. This website allows you to view the current student insurance enrollment for your campus.

In order to continue as a registered user for the upcoming 2015/2016 school year, you will need to re-register by clicking on the "Re-Register" button that will appear (post-7/1/2012) after successfully logging into the system. If the district/campus has renewed with ***HSR*** with the same policyholder name, the re-registration is automatic. If for some reason, the policyholder name has changed, manual intervention will be required. If manual intervention is required, please direct all questions to ClientRelations@hsri.com. Include **"Attention: Cassandra"** in the subject of your email.

Please allow up to 3 business days to process the request. In either case, your password will be reset and you will receive an email with instructions. Please direct all questions/comments to **ClientRelations@hsri.com.** Include "**Attention: Cassandra**" in the subject of your email.

Please note that since the data displayed on the website is personal in nature, security credentials to the site MUST be safeguarded and kept confidential and private.

ENROLL ONLINE NOW at www.K12StudentInsurance.com

HSR K-12 STUDENT INSURANCE PLANS

***HSR's* Student insurance products help protect kids from the bumps & bruises of growing up.**

How to Enroll

Enrolling online is easy & takes only a few minutes. Go to www.K12StudentInsurance.com

1. **Browse** the available 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).
   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. **Save your receipt** for future reference.

HSR
Health Special Risk, Inc.

K12 Accident Plans available through your school include:
At-School Accident Only, 24-Hour Accident Only, Extended Dental & Football.
If you have questions, please call us at **1-866-409-5733.**

Accident coverage underwritten by Mutual of Omaha Insurance Company, Omaha, Nebraska

Inscribase ahora en www.K12Student Insurance.com

HSR K-12 PLANES DE COBERTURA DE SEGURO PARA ESTUDIANTES

El producto de *HSR* Cobertura de Seguro para Estudiantes, ayuda a proteger a miles de niños/niñas de los golpes y moretones del crecer.

COMO INSCRIBIRSE

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

Por favor entre a la pagina www.k12studentinsurance.com

1. **Revise** 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). 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" arriba 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 recive su correspondencia y oprima el boton "**continue checkout**" al final de la pagina.
8. Para continuar con su orden, oprima el boton "**Pay and View Receipt**".
9. Guarde su recivo como **referencia**, por si lo necesita en el futuro.

Los planes de polizas K12 en caso de accidente o enfermedad, disponibles por su escuela incluyen: 24 horas solamente en caso de accidente; Extencion de plan dental y accidente durante el deporte de Futbol Americano.

Si tiene preguntas por favor llámenos al: 1 866 409 5733.

Cobertura de accidente suscrita por Mutual of Omaha Insurance Company, Omaha, Nebraska

2012OLEF20120427

2015-2016
ARKANSAS
K-12 INSURANCE
HIGH OPTION BENEFIT PLAN
VOLUNTARY RATE SCHEDULE

Coverage Underwritten by: Mutual of Omaha Insurance Company; Mutual of Omaha Plaza; Omaha, NE 68175

OPTION A: 24-HOUR COVERAGE	
Provides coverage for injuries incurred 24-Hours a day, 365 days a year (except injuries incurred while participating in High School Football events/activities).	
With Extended Dental	$101.00 Per Student
Without Extended Dental	$94.00 Per Student

OPTION B: AT SCHOOL COVERAGE	
Provides coverage for injuries incurred at school, during school sponsored and supervised activities (except injuries incurred while participating in High School Football events/activities).	
With Extended Dental	$32.00 Per Student
Without Extended Dental	$25.00 Per Student

OPTION C: FOOTBALL COVERAGE	
Provides coverage for injuries incurred while participating in sponsored and supervised practice or play for High School Football events Note: Any 9th grade student that plays with the High School Football Team (grades 10-12) must purchase Football coverage.	
With Extended Dental	$129.00 Per Student
Without Extended Dental	$122.00 Per Student

Extended Dental Coverage must be purchased in conjunction with a 24-Hour, At School or Football program, it cannot be purchased as a stand alone coverage.

2015-2016
ARKANSAS
K-12 INSURANCE
SCHEDULE OF BENEFITS

Coverage underwritten by Mutual of Omaha Insurance Company, Mutual of Omaha Plaza; Omaha, Nebraska 68175

Coverage is provided for loss due to a covered injury up to a maximum per injury benefit amount of $25,000 ($500 for Motor Vehicle Injuries). Treatment of covered injuries must begin within 60 days of the accident date. Only eligible expenses incurred within 52 weeks from the date of the accident are covered. The maximum benefit amount per service/treatment is as shown below. Benefits will be paid only for such expense which is not recoverable from any other insurance policy, service contract or workers' compensation.

INPATIENT:	**HIGH VOLUNTARY PLAN**
Room & Board	Semi-Private Room Rate/$200/ day maximum
Hospital Miscellaneous	Up to $150/ day, to a maximum of $750
Registered Nurse	100% of Allowable Expense
Physician's Nonsurgical Visits	Up to $35/ visit 1st day; $25/ visit each subsequent day
(Benefits are limited to one visit per day and do not apply when related to surgery)	
OUTPATIENT:	
Hospital Outpatient Surgery – Facility Charge	Up to $150/ injury
Physician's Nonsurgical Visits	Up to $35/ visit 1st day; $25/ visit each subsequent day
(Benefits are limited to one visit per day and do not apply when related to surgery or physiotherapy)	
Physiotherapy	100% of Allowable Expense/ $125 maximum per policy year (Benefits are limited to one visit per day)
Emergency Room	Up to $150/ injury
(Use of room and supplies; treatment must be rendered within 72 hours from time of injury)	
X-Ray Services (Includes charges for reading)	80% of Allowable Expense/$500 maximum per policy year
Laboratory	Up to $25/injury
Injections	Up to $25/injury
Prescription Drugs	$25 maximum per policy year
Orthopedic Braces and Appliances	$75 maximum
INPATIENT AND/OR OUTPATIENT:	
Surgeon's Fees	$172 coefficient value/$1,000 maximum (No more than one procedure through the same incision will be paid)
Anesthetist	25% of surgeon's allowance
Ambulance	100% of Allowable Expense
Treatment of Heat Exhaustion	100% of Allowable Expense
Dental	Up to $150 per tooth (Benefits are paid on sound natural teeth only)
Eyeglasses, Contact Lenses & Hearing Aids	100% of Allowable Expense for replacement if broken due to injury
Extended Dental Coverage	This is supplemental coverage for expenses resulting from covered accidental injuries. The dental benefits provided are: (a) 100% of Allowable Expense for examinations, X-Rays, endodontics and oral surgery to a maximum of $10,000 and (b) dental expenses toward the cost of bridges, dentures or replacement of previous dental repairs to a maximum of $250. No coverage is provided for orthodontics (braces) for any reason or damage or loss thereof.

2015-16 Contact Information for Arkansas K-12 Student & Athlete Insurance Programs

Your Arkansas K12 Insurance Agents

Keith Cargile – (817) 275-6453 - kcargile@sbcglobal.net

Kent Holbert – (903) 886-6943 - kholbert@koyote.com

Marion Turner – (903) 984-8048 - mmtt1940@live.com

HSR
Health Special Risk, Inc.

CLAIMS

Toll Free HSR Customer Service Claims Center: 1-866-409-5734
Open 8:00 AM – 6:00 PM daily
Electronic claim submission to: k12claims@hsri.com or via FAX (972) 512-5818

Jamie Luper, Customer Service Manager
(972) 512-5741 – jamieluper@hsri.com

Julie Daniel, Claims Manager
(972) 512-5713 – juliedaniel@hsri.com

Cathy Ray, Director of Claims & Customer Service
(972) 512-5710 – cathyray@hsri.com

SALES & POLICY SERVICE

Cassandra Talton, K-12 Program Team Leader
(972) 512-5660 - CassandraTalton@hsri.com

Tom Lenihan, President,
(972) 512-5700 - (972) 741-6507 (cell) - tomlenihan@hsri.com

Health Special Risk, Inc.
HSR Plaza II, 4100 Medical Parkway, Carrollton, Texas 75007
880 Sibley Memorial Highway, Suite 101, Mendota Heights, MN 55118
www.healthspecialrisk.com