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

STUDENT CLAIM FORM

1. Please fully complete this form
2. Attach itemized bills
3. Mail to *HSR*

E-mail : K12claims@hsri.com

HSR
Health Special Risk, Inc.

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

School District: Parkers Chapel Public Scools
City and State: El Dorado, AR
School Name: Parkers Chapel Public Schools
Policy Number: SR2014AR-P-101074

First Health.

* *DENOTES REQUIRED INFORMATION*

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	* City	* State	* Zip	7. Phone Number
8.* (If Minor) Parent's Name & Address	* City	* State	* Zip	9. Parent's Phone Number

10.* Date of Accident/Illness	11. Time of Accident ☐ a.m. ☐ p.m.	12.* Place where Accident Occurred	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	☐ During lunch hour	☐ Athletic period
☐ Not school related	☐ In school bus	☐ On school property during school hours
☐ P.E. class	☐ School sponsored field trip	☐ School sponsored activity during school hours
	☐ Traveling to/from school	☐ A spectator

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.

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** _____

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 (if applicable)

1. This policy may provide coverage on a secondary/excess basis. If you have any 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

HSR
Health Special Risk, Inc.

2019-2020

ARKANSAS K-12 INSURANCE
PREMIER PLUS - MANDATORY
SCHEDULE OF BENEFITS

Coverage is provided for loss due to a covered injury up to a maximum per injury benefit amount of $25,000 ($5,000 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. Coverage also includes $10,000 Accidental Death & Specific Loss.

INPATIENT:	
Room & Board	Semi-Private Room Rate
Intensive Care	1.5 times the Semi-Private Room Rate
Hospital Miscellaneous	Up to $750 first day, $250 per day thereafter to a maximum of $5,000
Registered Nurse	100% of Allowable Expense
Physician's Nonsurgical Visits	Up to $40 per visit
(Benefits are limited to one visit per day and do not apply when related to surgery)	
Orthopedic Braces and Appliances	Included in Hospital Miscellaneous Benefit
Family Travel (outside a 100 mile radius from home)	$400 per day/5 days maximum
OUTPATIENT:	
Hospital Outpatient Surgery – Facility Charge	Up to $1,500 per injury
Physician's Nonsurgical Visits	Up to $40 per visit
(Benefits are limited to one visit per day and do not apply when related to surgery or physiotherapy)	
Physiotherapy	Up to $25 per visit, up to $250 per injury (Benefits are limited to one visit per day)
Emergency Room	Up to $200 per injury
(Use of room and supplies; treatment must be rendered within 72 hours from time of injury)	
Physician Emergency Room	Up to $100 per injury
X-Ray Services (includes $50 for reading)	Up to $200 per injury
Cat Scan/MRI Services (includes $50 for reading)	Up to $750 per injury
Laboratory	Up to $50 per injury
Injections	Up to $25 per injury
Prescription Drugs	100% of Allowable Expense
Orthopedic Braces and Appliances	Up to $500 per injury (When prescribed by a physician for healing)
Durable Medical Equipment (Post Surgical Only)	Up to $150 per injury
INPATIENT AND/OR OUTPATIENT:	
Surgeon's Fees	90% of Allowable Expense up to a $2,500 maximum (Limited to the primary procedure per surgery)
Anesthetist/Assistant Surgeon	25% of surgeon's allowance
Ambulance	100% of Allowable Expense, first trip to the hospital
Treatment of Heat Exhaustion	100% of Allowable Expense
Dental	100% of Allowable Expense (Benefits are paid on sound natural teeth only)
Replacement of Eyeglasses, Contact Lenses & Hearing Aids	100% of Allowable Expense (When broken as a result of a covered injury)
Post Injury Concussion Management Testing	Up to $60/test, not to exceed three tests
Concussion Benefit	$100 in addition to other benefits

Insurance coverage underwritten by: Mutual of Omaha Insurance Company; 3300 Mutual of Omaha Plaza, Omaha, NE 68175