BOY SCOUTS OF AMERICA

1. PLEASE FULLY COMPLETE THIS FORM
2. ATTACH ITEMIZED BILLS WITH DOCTOR'S DIAGNOSIS
3. MAIL TO HEALTH SPECIAL RISK, INC.

HSR
Health Special Risk, Inc.

HSR Plaza
4001 North Josey Lane
Carrollton, TX 75007-1520
866-726-8870
Fax 972-492-4946

To be completed by BSA Leader
Council Name: _____
Address: _____
_____
Telephone Number: _____

ACE American Insurance Company

PART 1 - BSA Leader's Statement

Check One: ☐ Tiger Cub ☐ Tiger Cub Adult ☐ Varsity Scout ☐ Cub ☐ Scout ☐ Venturer ☐ Leader ☐ Committee
☐ Learning for Life – Explorer ☐ Seasonal Staff ☐ Other_____

Check Policy: ☐ Council ☐ Unit ☐ Campers & Special Events ☐ National Events

Post Number	Team Number	Troop Number	Pack Number

1. Name of Insured (Claimant)	2. Social Security Number - -	3. Sex __F __M	4. Birthday ___/___/___

5. Address of Insured
Street City State Zip

6. Parent's name, address and telephone number (include area code)

7. What date did accident happen or sickness begin?	8. Nature of injury or sickness (indicate part of body injured – such as broken arm, sprained ankle, etc.)

9. Describe how accident occurred – give details

FOR DENTAL CLAIMS ONLY	10. Indicate which teeth were involved in the accident	11. Describe condition of injured teeth prior to accident: ☐ Whole, sound and natural ☐ Filled ☐ Capped ☐ Artificial

12. Name of event or activity	13. Name and title of supervisor

14. Signature of policyholder representative X	15. Title	16. Date

PART 2 – Other Insurance Statement

Do you/spouse/parent have medical/health care coverage through your employer or other source on you? ☐YES ☐NO

If Yes, name of insurance company _____ Policy #_____

Is the Claimant enrolled as an individual, employee or dependent member of one of the following:
Preferred Provider Organization (PPO), Health Maintenance Organization (HMO) or similar prepaid health care plan, or any other type of accident/health/sickness plan? ☐YES ☐NO

If Yes, name of insurance company _____ Policy #_____

If your son/daughter has health care coverage as a dependent from your previous marriage as mandated in a divorce decree, please provide the following:

Name of Insurance Company _____ Policy #_____

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 participant or parent X	Witness	Date

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.

Authorization to pay benefits to provider

I authorize medical payments to physician or supplier for services described on any attached statements enclosed.

Signature X _____ **DATE** _____

Authorization for release of information

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 photostatic copy of this authorization shall be considered as effective and valid as the original.

Signature X _____ **DATE** _____

ATTACH ITEMIZED BILLS WITH DOCTOR'S DIAGNOSIS

HOW TO SUBMIT A CLAIM

You have been injured and you need to file a claim for consideration of benefits. How is that done? Below are basic items that need to be included in order to have your claim considered. Please keep in mind that we are not guaranteeing your claim will be paid, we are saying if all conditions are met, then this claim will be considered for payment.

There are three basic items that are required in order for a claim to be considered eligible for benefits.

1) **A Completed Claim Form**
   Please be sure to neatly and fully complete your claim form. If you do not have a claim form, please call ***HSR*** for assistance. Your claim form must have a policyholder's authorized signature. The policyholder representative is an employee or other administrator that acts on behalf of the policyholder to verify your claim. The policyholder will typically be your BSA or LFL Leader.

2) **Copies of Fully Itemized Bills**
   Please contact the providers of medical service directly for an itemized billing. An Itemized bill is usually in the HCFA-1500 or UB-92 format which means the bill should have a date of service, patient name, billing address and phone, provider tax identification number, procedural codes, and diagnosis code. If your bill does not have this information, please call the provider of service directly and request they mail it to us or call our office for assistance.

3) **Copies of Your Primary Insurance's Explanations of Benefits**
   The policy is excess to any other available source of medical benefits if the charges are greater than $300.00. This means that you must file your bills through your primary, or personal, insurance carrier prior to this policy responding. **If the total charges are less than $300.00, we will pay without the other insurance coordination.** When your primary insurance company processes the charges, they will send you an Explanation of Medical Benefits, or "EOB". You must forward a copy of the Explanation of Benefits for EACH CHARGE.

IF YOU DO NOT HAVE ANY OTHER AVAILABLE INSURANCE COVERAGE, fully complete Part 2 of the claim form as directed above, indicating "NO" in response to each insurance question, if appropriate. You ***MUST*** sign the insurance portion of the form if you have no other coverage. Please remember that this is a signed and sworn legal document.

For specific policy information, please call ***HSR*** to verify benefits. It is important to remember that policy wording or any verbal verification of benefits does not guarantee payment. It is important to remember that any statement of policy information does not guarantee the payment of any medical expense. Benefit determination can only be made once the entire claim and supporting documentation has been received and reviewed by the claims examiner.

Every policy has limitations on claim submission as well as on the benefit period, which is the period of time for which benefits are available for treatment for that injury from the date of injury. Treatment received past the benefit period is not eligible for benefits.

CONTACT INFORMATION

Health Special Risk, Inc.
4001 North Josey Lane
Carrollton, TX 75007
Toll Free Number 1-866-726-8870
Fax Number: 972-492-4946
Customer Service Email: claims@hsri.com