Student Accident Claims

Note to all parents with AIG Personal Accident Claim Form
Effective: July 1, 2021

All students within the Diocese of Jefferson City have access to a Student Accident Policy. This policy is a Full Excess Policy meaning if a student (Pre-K thru 12) is injured during school due to an accident it will pay covered medical expenses not covered by the student's individual health insurance, subject to limitations and exclusions **(payment is not guaranteed).** The policy is underwritten by National Union Fire Insurance Company of Pittsburgh, PA.

In addition to the fully completed Personal Accident Claim form attached (should be completed within 30 days of incident), AIG/National Union will need an itemized billing statement from each of the providers that were seen as a result of the injury (doctors office, hospital, etc). To receive the itemized billing statements, **you must call the hospital or clinic** and ask to speak with a representative in the billing department. The itemized billings go by the code UB-04, UB-92, CMS 1500, CMS 1200, or commonly known as the "HCFA" form. They can mail you a copy. ***Please note that the itemized billing statements are different from the billing statements you normally receive from the provider.*** AIG/National Union Fire will not accept an invoice for payment - it must be one of the itemized billing statements listed above.

The other item needed is the Explanation of Benefits (EOB) from your current medical insurance company, which shows the charges of each provider, what has been paid, and the balance due. There should be an EOB to match up to each provider's itemized statement. The Diocese student accident policy pays only after your primary medical insurance has paid.

All information should be mailed to the address below within 90 days of the incident. Once we receive this information from you, we will send all the information to AIG/National Union for processing. The processing of the claim takes approximately 6-8 weeks once they receive **all** the information needed.

You may contact Mary Baysinger (573-634-2122, x1320, mary.baysinger@winter-dent.com) at Winter-Dent with any questions. The Personal Accident claim form and all itemized billings should be mailed to:

Mary Baysinger
Winter-Dent & Co
PO Box 1046
Jefferson City, MO 65102

WINTER-DENT
100% EMPLOYEE OWNED COMPANY

AIG
Personal Accident Claims Department
P. O. Box 25987
Shawnee Mission, KS 66225
800-551-0824 (Telephone)
866-893-8574 (Facsimile)
AHClaims@AIG.com (Email)

PROOF OF LOSS

UNDERWRITTEN BY: NUFIC

NAME OF GROUP: William Shawn McKnight Bishop of Jefferson City, Catholic Diocese of Jefferson City

POLICY NUMBER: SRG 0009157688-A

PERSONAL ACCIDENT CLAIM FORM

INSTRUCTIONS:

1.) You must have SECTION A fully completed by a designated official of the Policyholder.
2.) SECTION B is to be completed, signed and dated by the claimant or parent/guardian of claimant, if claimant is a minor.

NEW YORK FRAUD STATEMENT: 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.

☐ PRIMARY PLAN - benefits are payable for covered medical expenses from the first dollar without regard to payments made by other insurance up to the policy maximum.

■ EXCESS PLAN - Eligible covered expenses will be determined after benefits have been paid by other valid and collectible insurance. You must submit your claim to your other insurance company first. When you receive their Benefit Statement (EOB) send it to us along with the itemized bills. Benefits for eligible expenses will be paid per policy terms.

The furnishing of this form, or its acceptance by the Company, must not be construed as an admission of any liability on the Company, nor a waiver of any of the conditions of the insurance contract.

SECTION A - MUST BE COMPLETED AND SIGNED BY A DESIGNATED REPRESENTATIVE OF THE POLICYHOLDER

NAME OF SCHOOL/ORGANIZATION		NAME OF SCHOOL DISCTRICT (IF APPLICABLE)	
CLAIMANT'S FULL NAME (PLEASE PRINT CLEARLY OR TYPE)	SOCIAL SECURITY NO. MANDATORY	DATE OF BIRTH	GENDER: MALE ☐ FEMALE ☐
WAS THE ACCIDENT RELATED TO AN ACTIVITY SPONSORED BY THE SCHOOL OR ORGANIZATION ? YES ☐ NO ☐	DATE OF INJURY OR FIRST TREATMENT FOR SICKNESS	IF SICKNESS PROVIDE DATE SYMPTOMS BEGAN	
NATURE OF INJURY OR ILLNESS. (DESCRIBE FULLY, INCLUDING WHICH PART OF BODY WAS INJURED.)	DESCRIBE HOW (PLEASE PROVIDE ALL DETAILS) AND WHERE ACCIDENT OCCURRED		

NAME OF ACTIVITY	DID ACCIDENT OCCUR:		
	A. WHILE CLAIMANT WAS SUPERVISED	☐ YES	☐ NO
	B. DURING SPONSORED ACTIVITY	☐ YES	☐ NO
INDICATE THE SPORT (IF APPLICABLE)	C. DURING PROGRAMMED HOURS	☐ YES	☐ NO
	D. WHILE TRAVELING TO OR FROM REGULARLY SCHEDULED ACTIVITY IN A SUPERVISED GROUP	☐ YES	☐ NO

POLICYHOLDER REPRESENTATIVE (PLEASE PRINT OR TYPE)	TITLE	DAYTIME TELEPHONE NUMBER
SIGNATURE OF POLICYHOLDER REPRESENTATIVE	DATE	NAME OF SUPERVISOR

SECTION B - MUST BE COMPLETED

DO YOU HAVE OTHER INSURANCE ☐ YES ☐ NO	IS THE OTHER INSURACE ONE OF THE FOLLOWING TYPES OF COVERAGE: ☐ GROUP (EMPLOYER) ☐ INDIVIDUAL ☐ GOVERNMENT ☐ MEDICAID	
LIST NAME, ADDRESS, AND PHONE # OF OTHER INSURANCE COMPANIES UNDER WHICH CLAIMANT IS INSURED. YOU MAY ALSO SEND A COPY OF THE INSURANCE ID:		POLICY # OR ACCOUNT #
IF CLAIMANT IS A MINOR, NAME OF CLAIMANT'S GUARDIAN/RELATIONSHIP TO CLAIMANT	BEST PHONE NUMBER	EMAIL ADDRESS
ADDRESS OF CLAIMANT (IF CLAIMANT IS A MINOR, NAME AND ADDRESS OF CLAIMANT'S GUARDIAN)		GUARDIAN'S SOCIAL SECURITY NUMBER
NAME/ADDRESS/TELEPHONE # OF EMPLOYER (IF CLAIMANT IS A MINOR, GUARDIAN'S EMPLOYER)		EMPLOYER'S DAYTIME TELEPHONE #

I HEREBY AUTHORIZE ANY COMMUNICATION BETWEEN THE POLICY HOLDER AND AIG AND IT'S AFFILIATES IN REGARDS TO THE ABOVE MENTIONED CLAIM AND RELATED MEDICAL EVENTS.

Signature **Date**

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

AUTHORIZATION and ASSIGNMENT OF BENEFITS

I, the undersigned authorize any hospital or other medical-care institution, physician or other medical professional, pharmacy, insurance support organization, governmental agency, group policyholder, insurance company, association, employer or benefit plan administrator to furnish to the Insurance Company named above or its representatives, any and all information with respect to any injury or sickness suffered by, the medical history of, or any consultation, prescription or treatment provided to, the person whose death, injury, sickness or loss is the basis of claim and copies of all of that person's hospital or medical records, including information relating to mental illness and use of drugs and alcohol, to determine eligibility for benefit payments under the Policy Number identified above. I authorize the group policyholder, employer or benefit plan administrator to provide the Insurance Company named above with financial and employment-related information. I understand that this authorization is valid for the term of coverage of the Policy identified above and that a copy of this authorization shall be considered as valid as the original. I understand that I or my authorized representative may request a copy of this authorization.

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE PHYSICIAN OR SUPPLIER FOR SERVICE PERFORMED. ☐ YES ☐ NO

CLAIMANT OR PARENT/GUARDIAN'S SIGNATURE **DATE**