ABCover Accident

Student Accident Insurance Claim Package

School Statement

Please complete all areas below in full. Once completed, provide the claim form to the injured student or, if the student is a minor, to the student's parent or guardian. They will complete the remaining sections and submit the completed claim form and supporting documentation directly to Davies Life & Health for claim processing. If you have any questions, do not hesitate to contact Davies Life & Health at:

(844) 304-3550 | DLHSTMMclaims@us.davies-group.com

Full Legal Name of Claimant _____ Claimant is ☐ Student ☐ Staff ☐ Volunteer ☐ Other _____

Claimant Phone _____ Claimant Email _____

Full Address of Claimant _____ Age _____ Date of Birth _____ Grade _____

Is other health coverage for the claimant on file with the school? ☐ Yes ☐ No

If ***Yes*** above, Name of Plan _____ Subscriber Name _____ Policy #_____

Name of School District _____ Name of School Site _____

Address of School _____ School Phone Number _____

Staff Member Supervising at Time of Injury (Name and Title) _____ Did They Witness the Injury? ☐ Yes ☐ No

Injury Occurred During: Interscholastic ☐ Game or ☐ Practice ☐ P.E. ☐ Field Trip ☐ Classroom ☐ Travel ☐ Other _____

Date of Injury _____ Time of Injury _____ ☐ AM ☐ PM Date Injury Was Reported to the School _____ Sport _____

Injured Body Part Area _____ ☐ Right ☐ Left Has This Condition Happened Before? ☐ Yes ☐ No If Yes, When? _____

Please Describe How and Where the Injury Happened

What Immediate Action Was Taken by Staff? ☐ First aid ☐ Called EMS ☐ Escorted to Office ☐ Other _____

I certify that the activity checked above is school sponsored and supervised and that the above information is correct to the best of my knowledge and belief.

Completed by (Name and Title) _____ Email _____

Phone Number _____ Signature _____ Date Signed _____

Thank you for your attention to this process. The next section is intended for the parent or guardian of the injured student (or for the student, if they are not a minor). Once the above section is completed, please forward this entire document to them and retain a copy for your records. Whenever possible, we recommend using email, as it creates a documented trail of communication.

Once the student or parent/guardian submits the completed claim form, Davies Life & Health will work directly with them throughout the claim process. If your school has questions or needs an update regarding a claim, you are always welcome to contact Davies for assistance.

Instructions for Parent, Guardian, or Students of Legal Age

We understand how stressful and disorienting a student injury can be. If you have questions or need support at any point, please contact Davies Life & Health for assistance. They may be reached at **(844) 304-3550** or **DLHSTMMclaims@us.davies-group.com**

We also recommend scanning the QR code below to instantly save their contact information to your phone, so it is always accessible if needed.

Please read the instructions below to ensure your claim is processed as quickly as possible.

The first step is determining whether you do or do not have health insurance, as the claim process differs depending on your coverage.

If you DO have health insurance
(other than Medicaid, Medicare, or Tricare):

- This policy functions as a Secondary (or Excess) Insurer to your primary health insurance plan.
- File a claim with your primary insurance first, following their network requirements and referral procedures.
- Once your health insurance has processed the claim, send Davies any available Explanation of Benefits documents *(click here for a sample).*
- While your primary health insurance is processing the claim, you may proceed with the remaining steps below.

If you DO NOT have health insurance
(or are a recipient of Medicaid, Medicare, or Tricare):

- This policy functions as a Primary Insurer.
- If you are covered by one of the government funded plans above, claims should not be submitted to your government funded plan.
- You may seek any provider you would like but, out-of-pocket costs may be lower if you use a provider participating in the Prime Health Services network. To find a provider:
  - ✓ Visit: https://search.primehealthservices.com/Search and set your location
  - ✓ Select the "Group Health" as the network
  - ✓ Select the provider type (Physician, Hospital, Rehabilitation, etc.)
  - ✓ You may then narrow your search further by provider name, address, radius and more.
  - ✓ For further assistance, contact Davies at (413)-747-1545 or DLHSTMMclaims@us.davies-group.com
  - ✓ You may also contact Jane Star, ABCover Claims Specialist, at (714) 767-9481 or jane.starr@abcover.org.
- Proceed with the remaining steps below

Some medical providers may not be familiar with student accident insurance so give their billing office the ***"Information for Providers"*** document that was provided to you in addition to this packet. It can help expedite this process by explaining how they should bill Davies Life & Health.

Davies Life & Health may contact you for additional information. Please respond promptly to requests for information and/or documentation.

Check your email regularly (including spam and junk folders) and add emails from **@us.davies-group.com** to your safe sender list.

Monitor for incoming calls from the **413** area code and monitor voicemail messages. If you use a spam-call blocking service, make sure claim-related calls can reach you.

Please complete the information on the next two pages. If you are unable to complete any section, contact Davies Life & Health before submitting your claim. Just a 2-minute phone call can prevent weeks of delays.

Parent, Guardian, or Students of Legal Age Statement

Preferred Contact Method: ☐ Email ☐ Phone

Full Legal Name of Claimant _____ Phone Number _____ Email _____

The Claimant Has: ☐ Primary Health Insurance, Name of Plan _____ ☐ Medicaid ☐ Tricare ☐ Medicare

☐ Other _____ ☐ No Insurance in Place

Please attach a copy of any applicable insurance card (front and back)

Claimant Employment Status: ☐ Full-Time ☐ Part-Time ☐ Self-Employed ☐ Unemployed Employer's Name _____

Employer's Address _____ Phone Number _____ Email _____

If the claimant is under age 26 and covered by a parent or guardian's health plan, please complete the Parent/Guardian Information section below. If the claimant is age 26 or older, you may skip this section and proceed to the Signature areas below and Authorization.

Name Parent or Guardian #1 _____ Email Address _____

Address _____ Phone Number _____

Employment Status: ☐ Full-Time ☐ Part-Time ☐ Self-Employed ☐ Unemployed If Applicable, Employer's Name _____

Employer's Address _____ Phone Number _____ Email _____

Name Parent or Guardian #2 _____ Email Address _____

Address _____ Phone Number _____

Employment Status: ☐ Full-Time ☐ Part-Time ☐ Self-Employed ☐ Unemployed If Applicable, Employer's Name _____

Employer's Address _____ Phone Number _____ Email _____

Notice Regarding Insurance Fraud

Providing false, incomplete, or misleading information when filing an insurance claim may be considered insurance fraud—a criminal offense that can result in legal prosecution and civil penalties. I have read and acknowledge this notice, including any additional state-specific language on the reverse side.

Benefit Payment Authorization

I give permission for payment to be made directly to the provider(s) of medical care or services connected to this claim.

Name _____ Relationship to Claimant _____ Signature _____ Date _____

Supporting Documentation

To help us process your claim as quickly as possible, please submit any of the documents below if you already have them available. If you do not have them yet, that's okay. As your claim progresses, Davies Life & Health may request them if needed.

Document	Description	Need to See a Sample?
Health Insurance Card	A statement from your health insurance company showing how your medical claim was processed.	***Click Here***
Explanation of Benefits (EOB)	If applicable, your primary health insurance card showing your insurance company, member ID, and policy information.	
CMS-1500	An itemized bill from a physician or other healthcare provider.	
UB-04	An itemized bill from a hospital or other healthcare facility.	

Checklist

- ☐ Complete the Statement above in full.
- ☐ Complete and sign the attached Authorization form on the next page.
- ☐ Gather any supporting documents you already have available.
- ☐ Mail, fax, or email **all 4 pages** of this completed packet, along with all other correspondence to:

Davies Life & Health, Inc., A Third Party Administrator for
Certain Underwriters at Lloyd's, London

1500 Main Street, Suite 1400, Springfield, MA 01115-5189

Phone: (844) 304-3550 | Fax: (413) 747-1545 | DLHSTMMclaims@us.davies-group.com

Davies Life & Health, Inc., A Third Party Administrator for:
Certain Underwriters at Lloyd's, London
1500 Main Street, Suite 1400
PO Box 15189
Springfield, MA 01115-5189

Phone
(413) 747-0990
(800) 883-0596

Fax
(413) 747-1545

Name of Insured:	Social Security Number: (if applicable) xxx-xx-
Name of Authorized Representative if Insured is a minor:	

HIPAA (Health Insurance Portability and Accountability Act) Compliant Authorization To Obtain Information

I authorize any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance company, employer, school, the Social Security Administration, consumer reporting agency, pharmacy benefit manager, or any other person or organization having any information, whether fact or opinion, regarding illness, injury, medical history, diagnosis, treatment, prescription history, and prognosis with respect to the past, present or future physical or mental condition and treatment, including drug and alcohol abuse treatment, of the insured and any other non-medical information of the insured to give Certain Underwriters at Lloyd's, London, or its authorized representative ("Certain Underwriters at Lloyd's, London") any and all such information required by them to determine my eligibility for policy claim benefits.

I authorize Certain Underwriters at Lloyd's, London to request dates of past and present claims and names of insurers, but not medical or personal information, from the Health Claims Index operated for subscriber insurers by MIB, Inc. ("MIB"), and association of life insurance companies. I understand such information may be reported to MIB. MIB, upon request, may disclose such information about me in its file to: another member company with whom I apply for life or health insurance, or to whom I submit a claim for benefits; a governmental agency; a party to a legal or arbitration proceeding as required by law, or for other purposes as required or permitted by applicable law.

Use and Disclosure

Information obtained by use of the Authorization will be used by Certain Underwriters at Lloyd's, London to determine eligibility for benefits under an insurance policy. Any information obtained will not be released by Certain Underwriters at Lloyd's, London, to any person or organization except to medical professionals who I or Certain Underwriters at Lloyd's, London have asked to assess my medical condition, reinsuring companies, third party administrators, claim consultants or other persons or organizations performing business or legal services in connection with this claim or as may be otherwise lawfully required or as I may further authorize.

Information that I disclose to Certain Underwriters at Lloyd's, London for the purpose of determining my eligibility for coverage may be appropriately re-disclosed to third parties, as described above, and such third parties' subsequent disclosure of the information may not be limited by applicable state and/or federal privacy laws.

Agreement and Acknowledgment

I know that I may request to receive a copy of this Authorization.
I agree that a photocopy of this Authorization shall be as valid as the original.
I agree that this Authorization shall be valid for the duration of my current claim or twenty-four (24) months, whichever is shorter, unless I revoke this Authorization in writing by sending a letter to the claims representative assigned to my claim.
If I revoke this Authorization, I recognize that Certain Underwriters at Lloyd's, London may continue to consider any information that it has already obtained to evaluate my claim and may continue to gather additional information to the extent that this Authorization is not needed to gather such information. However, I understand that as a result of my revocation of this Authorization, Certain Underwriters at Lloyd's, London may be unable to gather sufficient proof to support my claim and therefore may not provide benefits.

Insured's Signature:_____ **Date**:_____
(Insured if over 18 years or age and had legal capacity or Insured's representative)

_____
(Relationship to claimant if authorized representative)