1. **Please Fully Complete This Form**
2. **See Filing Instructions Attached**
3. **Mail To**

90 Degree Benefits
PO Box 6540, Harrisburg, PA 17112
Customer Service Hours: Mon-Fri 8a-4p EST
Phone: 1-800-427-9308
Fax: 717-652-8328
Email: Student.Insurance@90degreebenefits.com

PART I - PARTICIPATING ORGANIZATION STATEMENT

Policy Number:	Organization Name:	Event, Activity, or Sport:
KAMB-168191	Manchester Public Schools, CT	

Claimant's Name (Injured Person)	The Injured Person Was A: ☐ Participant ☐ Staff Member ☐ Other	Date and Time Of Accident:
Place Where Accident Occurred:	Type of Injury: (Indicate Part Of Body Injured and what side - e.g. broken left arm, etc.)	

Describe How Accident Occurred - Provide All Possible Details:

Dental Claims	Indicate Which Teeth Were Involved:	Describe Condition of Injured Teeth Prior To Accident: ☐ Whole, Sound & Natural ☐ Filled ☐ Capped ☐ Artificial

Did Accident (Check Yes or No for Each of The Following):

A.	During A Participating Organization Sponsored & Supervised, or Sanctioned Activity?	☐ YES	☐ No
B.	On Activity Premises:	☐ YES	☐ No
C.	While Traveling Directly and Uninterruptedly to Or Form the Activity?	☐ YES	☐ No
D.	During A Participating Organization Practice or Competition?	☐ YES	☐ No
E.	Did Injury Result in Death:	☐ YES	☐ No

Signature of Participating Organization Representative:	Name & Title of Participating Organization Representative:	Date:

PART II - PARENT, RESPONSIBLE PARTY, OR GUARDIAN STATEMENT

Best Contact Number (Included Area Code):	Social Security Number (Of Injured):	Gender (Of Injured): ☐ M ☐ F	Date of Birth (Of Injured):

Address (in which information should be mailed to):

Do you/spouse/parent have medical/health care, or are you 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 an employer, a parent's employer, or other source? ☐ YES ☐ No

If yes, name of insurance company: _____ Policy #: _____

Are you eligible to receive benefits under any governmental plan or program, including Medicare? ☐ YES ☐ No

If yes, please explain: _____

Mother (Guardian's) primary employer name, address & telephone: _____

Father (Guardian's) primary employer name, address & telephone: _____

PART III - AUTHORIZATIONS

I authorize medical payments to physician or supplier for services described on any attached statements. If not signed, provide proof of payment.

SIGNATURE: _____ **DATE:** _____

I authorize any physician, medical professional, hospital, covered entity as defined under HIPPA, insurer or other organization or person having any records, dates or information concerning 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 or all such records in their entirety to **AXIS Insurance Company** or its designated administrator. A photo static copy of this authorization shall be considered as effective and valid as the original.

I agree that should it be determined at a later date there is other insurance (or similar), to reimburse **AXIS Insurance Company** to the extent of any amount collectible. I understand that any person who knowingly and with the intent to defraud or deceive any insurance company; files a claim containing any material by false, incomplete, or misleading information, may be subjected to prosecution for insurance fraud.

SIGNATURE: _____ **DATE:** _____

CLAIM PROCEDURES

1. Submit all itemized bills to both your family insurance carrier and the insurance carrier for your school/organization. These bills are generally a HICFA form (Physician) or a UB92 form (Hospital). The Physician or Hospital has an assignment of Benefits on file; which was completed on the initial treatment visit. This assignment of Benefits will be honored. If your Provider does not bill on a HICFA or UB92 Form, You will need to sign the authorization to pay Benefits to the Provider on the front of this form.
2. If your family insurance carrier is an HMO organization, CONTACT YOUR HMO PHYSICIAN AT ONCE. FAILURE TO DO SO MAY RESULT IN THE CLAIM BEING DENIED OR A SUBSTANTIALLY REDUCED BENEFIT .
3. Your family insurance carrier will send you an Explanation of Benefits (E.O.B.) listing the payments made by them. Upon receipt of the E.O.B., forward the E.O.B. along with any unpaid itemized bills and a completed claim form to the claim administrator: 90 Degree Benefits for processing: **paid receipts and/or balance due statements are not accepted**.
4. If you do not have other valid and collectible insurance (Auto, Employer Provided, Family Insurance or Self-Provided): complete the information on the claim form, sign where indicated, include all your itemized bills, receipts, etc., and forward to the claim administration for processing.

FRAUD 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.

THINGS TO REMEMBER

1. TO SUBMIT ADDITIONAL BILLS AFTER THE ORIGINAL FORM HAS BEEN SENT IN, BE SURE TO INCLUDE THE FOLLOWING: (A) NAME OF CLAIMANT; (B) DATE OF ACCIDENT; (C) NAME OF THE POLICYHOLDER (SCHOOL, COLLEGE OR ORGANIZATION).
2. IF YOUR FAMILY INSURANCE CARRIER IS AN HMO ORGANIZATION, CONTACT YOUR HMO PHYSICIAN AT ONCE.
3. PROOF OF LOSS IS REQUIRED WITHIN 90 DAYS FROM THE DATE OF THE ACCIDENT. YOU HAVE ONE YEAR FROM THE TIME PROOF OF LOSS WOULD HAVE BEEN REQUIRED TO FILE A CLAIM. CLAIMS SUBMITTED PAST THIS PERIOD WILL NOT BE CONSIDERED FOR PAYMENT UNDER THE POLICY.
4. AUTHORIZATION TO RELEASE MEDICAL INFORMATION (MUST BE SIGNED)
5. PAYMENT WILL BE MADE TO THE SOURCE OF SERVICE (HOSPITAL, PHYSICIAN, ETC.) UNLESS CLAIM FORM ACCOMPANYING THE BILL INDICATES OTHERWISE AT THE TIME THE CLAIM IS SUBMITTED. IF YOU PAID FOR THE SERVICES AND REIMBURSEMENT IS TO BE PAID TO YOU, PROOF OF PAYMENT WILL BE REQUIRED AT THE TIME THE CLAIM IS SUBMITTED.

IMPORTANT NOTICE

This Brochure provides a brief description of the important features of the insurance plan. It is not a contract of insurance. The benefits, terms and conditions of coverage are set forth in the policy issued in Connecticut under form number BACC-001-0909-CT. Complete details of coverage are found in the policy on file at your school's office. The policy is subject to the laws of the state in which it was issued. Please keep this information for your reference.