SCHOOL'S REPORT OF ACCIDENT

Complete this form and return within 90 days of the accident. Please send **itemized** bills only; balance due bills cannot be processed. Only one form is necessary per accident. Show school name and policy number on additional bills.

Send this claim form, PRIMARY INSURANCE EXPLANATIONS OF BENEFITS, and ITEMIZED BILLS to:

A-G ADMINISTRATORS, INC.
P.O. BOX 979, VALLEY FORGE, PA 19482

Fraud Warning: Any person who, knowingly and with intent to defraud, or helps commit a fraud against, any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits or may be committing a fraudulent insurance act, which is a crime and subjects such person to criminal and/or civil penalties. For residents of the following states, please see end of the form: California, Colorado, District of Columbia, Florida, New York, Tennessee, Texas or Virginia.

Name of School _____ Policy No. _____ STUDENT'S SOCIAL SECURITY NUMBER _____

School System _____ Name of Student _____

Student Covered: ❑ Schooltime ❑ 24 Hr. ❑ Dental ❑ All Sports ❑ Football Student's Birthdate _____ Grade _____

Name & Address of Parent or Guardian _____

1. Date & Time of Accident _____ ❑ AM ❑ PM
2. COMPLETE details of accident _____
3. Nature of Injury _____
4. Did accident occur while:
   (a) Attending school during hours and days school in session? ❑ No ❑ Yes On home premises? ❑ No ❑ Yes
   (b) Traveling to or from school? ❑ No ❑ Yes If yes, was student on usual and direct route? ❑ No ❑ Yes
   (c) Engaged in a school sponsored and supervised activity? ❑ No ❑ Yes Name & place of activity _____
   (d) Was student participating in an Intramural sport? ❑ No ❑ Yes An Interscholastic sport? ❑ No ❑ Yes What sport? _____
5. Names and addresses of attending physicians _____

I hereby certify that the above answers are complete, true, and correct to the best of my knowledge and belief.

SIGNATURE OF SCHOOL OFFICIAL (Required on all claims except 24 hour coverage) **TITLE** **DATE**

SIGNATURE OF PARENT OR GUARDIAN (Parent please complete reverse side of claim form) **DATE**

PHYSICIAN'S OR DENTIST'S REPORT

1. Nature of Injury _____ 2. Date of First Treatment _____
3. Has patient ever had the same or similar condition? ❑ No ❑ Yes If yes, state when and describe _____
4. Nature of Surgical Procedure, if any & procedure code _____
5. Dates of Treatment: _____ Description: _____ Charge: _____
6. Has patient been discharged from treatment? ❑ No ❑ Yes If yes, give date _____ **TOTAL CHARGE:** _____
7. Was patient confined to a hospital? ❑ No ❑ Yes If yes, give name & address of hospital & dates confined _____
8. **TO WHAT OTHER INSURANCE COMPANY HAVE YOU REPORTED THIS CLAIM?** (INCLUDE NAME & ADDRESS) _____

9. List teeth involved and indicate on chart. _____
10. Describe condition of injured teeth prior to accident.
    1. CARIOUS ❑ 2. FILLED ❑ 3. WHOLE ❑ 4. CAPPED OR ARTIFICIAL ❑ 5. SOUND & NATURAL

NOTICE OF A LEGAL REQUIREMENT: Insert your Tax Identification Number as required by Section 6041 of the Internal Revenue Code.
(CLAIM CANNOT BE PROCESSED WITHOUT THIS INFORMATION.)

COMPANY USE ONLY

PHYSICIAN'S SIGNATURE **DATE**

PHYSICIAN'S NAME AND ADDRESS _____
NAME (PLEASE PRINT OR TYPE) ADDRESS

HOSPITAL REPORT (ATTACH ITEMIZED HOSPITAL BILL, IF ANY)

THIS SECTION MUST BE COMPLETED BY PARENT OR GUARDIAN

IF BLUE CROSS (HOSPITALIZATION) GROUP # CONTRACT # SERVICE CODE #	IF BLUE SHIELD (PHYSICIAN'S CARE) GROUP # CONTRACT # SERVICE CODE #
NAME & ADDRESS OF MOTHER'S EMPLOYER	NAME & ADDRESS OF FATHER'S EMPLOYER

DO YOU HAVE MEDICAL INSURANCE OTHER THAN BLUE CROSS? ❑ Yes ❑ No	IF SO, NAME OF COMPANY	POLICY NUMBER

ADDRESS OF OTHER INSURANCE COMPANY NAMED ABOVE	TYPE OF PLAN FROM THIS COMPANY ❑ Individual ❑ Group

AFFIDAVIT

I verify that the above statement on other insurance is accurate and complete. I understand that the intentional furnishing of incorrect information via the U.S. Mail may be fraudulent and violate federal laws. I agree that if it is determined at a later date that there are other insurance benefits collectible on this claim I will reimburse the school's insurance company to the extent of any amount collectible.

SIGN: Parent or Guardian_____ Date _____

If Insured is hospital confined, please complete AUTHORIZATION below and return immediately to eliminate any delay in completion of claim.

AUTHORIZATION

I authorize any physician and/or hospital to release such information as relates to this claim to The Insurance Company or the Company's authorized Claims Administrator.

Signature _____ Date _____

AUTHORIZATION TO PAY BENEFITS TO PROVIDER

I authorize payment of Medical payments to Physician or Supplier for Services described on the reverse side.

SIGN: Parent or Guardian_____ Date _____

FRAUD WARNING

California & Texas Residents: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado Residents: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

District of Columbia Residents: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida Residents: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

New York Residents: 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.

Tennessee Residents: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Virginia Residents: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.