Plan Underwritten and Administered by:

COMMERCIAL TRAVELERS
LIFE INSURANCE COMPANY
COMMERCIAL TRAVELERS BUILDING
UTICA, NEW YORK 13502

For Toll-free Policyholder Service 1-800-756-3702 • Utica area 315-797-5200

Instructions

- School Official completes Part A.
- Parent/Guardian completes Part B. The Claim Form must be fully completed. Forms not fully completed may cause the Claim Representative to return the Claim Form resulting in processing delays.
- Please submit the completed Claim Form within 90 days from the date of accident.
- Submitting the appropriate documentation is essential for timely adjudication of your claim expenses. Note: If you are receiving treatment from a provider (primary care physician), please request a CMS 1500. If you are receiving treatment from a hospital, please request a UB04.
- Please submit any Notice of Payment or Rejection (explanation of benefits—EOB) forms from your health insurance carrier. Any itemized billing statements submitted must include a diagnosis code and procedure code.
- Please notify all physicians, hospitals and any other healthcare providers that have or will be treating your child and provide them with these instructions. Please ask the providers to forward bills to the claims administrator at:

Commercial Travelers Life Insurance Company
Attn: K–12 Claim Administration • 70 Genesee Street. Utica NY 13502 • Fax No. 315-797-0195

Notice: When we are the secondary plan, we do not pay until after the primary plan has paid its benefits if any. We will review Usual & Customary charges of each plan and allow the highest. Any amount paid by your primary plan for an eligible expense under our plan may satisfy all or a portion of our deductible.

Accident Claim Form

Please print or type

Part A: School Report

Instructions — school official completes this Part A, then gives the form to the student's parent or guardian to complete Part B on the reverse side. **Parent must provide name of school/school district, if not school related accident.**

If you have submitted an accident report to another insurance company, please attach a copy.

Name of School Phone No. ( )	School District/Policyholder
Address Street/Box# City State Zip	Policy No.
Name of Student	❒ Male ❒ Female — Grade

Date of Accident / /	How Accident Occurred ❒ Enroute to/from school ❒ During school session ❒ Practice or play of interscholastic sports Name of Sport _____ ❒ JV ❒ Varsity ❒ Other _____
Time of Accident ❒ AM ❒ PM	

How did accident happen?

Details of Injury — including part of body injured ❒ Left ❒ Right: _____

Name of Teacher or Coach Supervising the Activity

FOR RESIDENTS OF ALL STATES OTHER THAN THOSE LISTED ON PAGE 3: Any person who knowingly, and with intent to defraud, injure or deceive any insurance company, files or causes to be filed, a claim for payment of a loss, containing any false or incomplete information commits a fraudulent insurance act that may be a crime and may subject such person to confinement in prison, fines and denial of benefits.

Signature of School Official/Title	Date Signed

—Reverse side must be completed by parent or guardian—

Accident Claim Form

Please print or type

Part B: Statement of Parent or Guardian

Name of Injured Student	Social Security No.	Date of Birth / /	Date of Accident / /

Name of Person Making this Report — Relationship to Student

Address — Telephone

Street/Box# City State Zip — Home ( ) _____ Work ( ) _____

Name of Student's **1st Parent** or Guardian	Occupation	Social Security No.
Address if different from student		

Employer's Name and Address

Name Street/Box# City State Zip Phone #

Name of Student's **2nd Parent** or Guardian	Occupation	Social Security No.
Address if different from student		

Employer's Name and Address

Name Street/Box# City State Zip Phone #

Does either parent or guardian have Accident/Health Insurance which covers this student? ❒ Yes ❒ No
If yes, which person(s)

Name of Insurance Company(ies)	Name of Policyholder(s)

For Around-the-Clock Coverage only:

Date of injury (or) onset of sickness _____ When was physician first consulted? _____

Nature of injury (or) illness _____

If injury, how and where did accident occur? _____

Have you suffered same or similar condition in the past? ❒ Yes ❒ No If "Yes,' and if you were treated for, it, please give name and address of the physician who treated you _____

Dates treated _____

Give name, address and telephone number of usual family physician _____

_____ Phone _____

I hereby authorize any physician, hospital, company, employer, or organization to release any information regarding the medical history, treatment, or benefits payable for this claim, to the Insurance Company stated above or its authorized benefit plan administrator. A photostatic copy of this authorization shall be as valid as the original.

I also authorize the Insurance Company or their representatives to pay all bills in connection with this claim directly to the doctor, hospital or any other persons rendering service, and such payment shall release the Insurance Company from liability as to amounts so paid.

I hereby certify that I have read the answers to all parts of this form and to the best of my knowledge and belief the information is complete and correct as given herein.

Name of Student _____

FOR RESIDENTS OF ALL STATES OTHER THAN THOSE LISTED ON PAGE 3: Any person who knowingly, and with intent to defraud, injure or deceive any insurance company, files or causes to be filed, a claim for payment of a loss, containing any false or incomplete information commits a fraudulent insurance act that may be a crime and may subject such person to confinement in prison, fines and denial of benefits.

Signature of Parent or Guardian	Date Signed

AK, CT, DE, HI, IA, ID, IL, IN, MI, MN, MO, MT, MS, NC, ND, NV, SC, SD, UT, WI & WY: Any person who knowingly and with intent to defraud an insurer submits a written application or claim containing any materially false or misleading information is guilty of insurance fraud.

AL, AR, DC, LA, MA, and RI: 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.

AZ: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

CA: For your protection California law requires the following to appear on this form: 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.

CO: 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."

FL: 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.

GA, NE, KS, OR, TX, VT: Any person who knowingly and with intent to defraud an insurer submits a written application or claim containing any materially false or misleading information may be guilty of insurance fraud.

KY: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

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

MD: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NH: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud.

NJ: Any person who includes any false or misleading information on an application or statement of claim for an insurance policy is subject to criminal and civil penalties.

NM: 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 CIVIL FINES AND CRIMINAL PENALTIES.

NY: Any person who knowingly and with intent to defraud any insurance company or other person files an application for health insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, any 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 $5,000.00 and the stated value of the claim for each such violation.

OH: Any person who, with 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 is guilty of insurance fraud.

PA: 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.

OK: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

TN: 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.

VA, WA: 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 or a denial of insurance benefits.

WV: 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.