STUDENT ACCIDENT CLAIM FORM

SUBMIT CLAIM FORM TO: **Unified Life Insurance Company**
c/o Universal Fidelity Life Insurance Company
P.O. Box 304
Duncan, OK 73534-0304
(800) 366-8354

Section 1 - Notice of Injury **(To be completed by School Official)**
(This section may be completed by parent if 24-Hour coverage was purchased and accident is not school-related)

Name of School District:

Name of School: School Phone No:

Name of Injured Student: □ Male □ Female Grade:

Date of Injury: Time of Injury: □ AM □ PM

Part of Body Injured: □ Right Side □ Left Side

Under whose supervision?

Was accident witnessed? □ Yes □ No If "Yes", by whom?

The accident happened while the student was participating in:
□ Interscholastic UIL Activity □ Non Interscholastic UIL Activity
Specify Sport/Activity:

Explain in detail how and where the injury occurred: _____

_____

_____

_____

_____

Signature of School Official: _____
(Title) (Date)

IMPORTANT INFORMATION ON REVERSE SIDE

Section 2 - Parent/Guardian Statement **(To be completed by Parent/Guardian)**

Name of Student: Date of Birth: Home Phone No:

Is student covered by any insurance plan? □ Yes □ No If yes, Policy No.

Parent/Guardian Name: Relationship to Student:

Address: _____
(Street) (City) (State) (Zip)

Father's Name: Father's Employer:

Name of Father's Insurance Company (must be completed - If Father has no insurance - write "None"):

Insurance Company: Policy No.

Mother's Name: Mother's Employer:

Name of Mother's Insurance Company (must be completed - If Mother has no insurance - write "None"):

Name of Insurance Company: Policy No.

I hereby authorize any insurance company, their authorized agent, hospital, physician, employer, school official or other person who has attended or examined the claimant to disclose when requested to do so all information with respect to any injury, policy coverage, medical history, consultations, prescription or treatment, and copies of all hospital or medical records, and itemized bills. A photo static copy of this authorization shall be considered as effective and valid as the original. I swear that the above information is true and correct to the best of my knowledge. **I further understand that any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.**

_____ _____ _____
(Date) **(Print Name of Student)** **(Signature of Parent/Guardian)**

Form CLM-2 (10)

ATTENTION PARENTS

Dear Parents,

Below are instructions for filing the Claim Form. Should you have any questions, contact the school trainer or call the number listed below. The school is **NOT** responsible for medical payment for your child. The school may have purchased a supplemental Accident Only Policy which may cover charges in excess of your own insurance policy. If you have no other insurance for your child, this policy may pay first or primary. This is a limited benefit policy and may not cover all medical bills for your child. Any charges not covered are **YOUR RESPONSIBILITY.**

For all school-related accidents, be sure to contact the school trainer or administrator.

INSTRUCTIONS FOR FILING THE CLAIM FORM

Section 1 must be completed by a school official for all school-related accidents and by the parent / guardian if 24-Hour coverage was purchased and the accident is not school-related.

Section 2 must be completed by the parent / guardian.

How to File A Claim

Step 1 - **Complete and submit the claim form to the Claims Office at the address indicated below or send electronically to SAclaims@uflic.com.** The claim form must be submitted within 90 days from the date of injury regardless of whether you have other insurance or not. Keep a copy of the claim form for your records and present a copy of the claim form to the provider or facility. **DO NOT RELY on the provider or facility to submit the claim form.**

Submit copies of itemized bills to the address indicated below. Itemized bills are original bills you receive, not monthly statements. Itemized bills are often called UB92 or HCFA1500 forms that provide the procedure code, diagnosis code, and the Providers' address and Tax ID Number.

Step 2 - **File a claim with your primary insurance first.** Submit copies of all bills to your primary insurance first. Your primary insurance is your family and/or group insurance coverage. The school's policy is supplemental to all other valid coverage.

Step 3. After receiving payment or copies of Explanation of Benefits (EOB) from your family and/or group insurance, **submit a copy of this claim form along with copies of your itemized bills and EOBs from your primary insurance company to the address below:**

Unified Life Insurance Company
c/o Universal Fidelity Life Insurance Company
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Duncan, OK 73534-0304
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Texas Kids First has unique access to one of the most creative innovations in the insurance industry – the Texas Kids First Provider Network (TKF Network)* – the first "no balance bill" non-profit network of providers in the State. The network consists of medical professionals and hospitals that have agreed to treat injured students from our insured districts for the services paid and outlined in the Schedule of Benefits of the Texas Kids First Student Accident Plans when the student patient has no other insurance.

Please refer to the website www.texaskidsfirst.com or call **1-800-366-8354** for a list of contracted providers in your area and to verify full assignment acceptance.

*The TKF Network is made available by Texas Kids First and is not affiliated with Unified Life Insurance Company.

FRAUDULENT CLAIM DISCLOSURE

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