RISK strategies
Academic HealthPlans

Risk Strategies Company
On behalf of Nationwide Mutual Insurance Company
P.O. Box 25936
Overland Park, KS 66225

ACCIDENT CLAIM FORM

TO BE COMPLETED BY PARENT/PARTICIPANT

NAME OF PARTICIPANT (Last Name) (First Name) (Middle Initial) | SOCIAL SECURITY NUMBER

PARTICIPANT ADDRESS (Street) (City) (State) (Zip)

PHONE NUMBER | DATE OF BIRTH | MALE ❑ FEMALE ❑

DATE OF INJURY | TIME OF INJURY | TYPE OF ACTIVITY

PLEASE MARK: _____ PRACTICE _____ GAME _____TRAVEL OTHER _____
_____ INTRAMURAL SPORT _____ INTERSCHOLASTIC SPORT | TYPE OF INJURY

DESCRIBE FULLY HOW AND WHERE THE INJURY OCCURRED _____

PARENT/GUARDIAN NAME (Last Name) (First Name) (Middle Initial)

ADDRESS (Street) (City) (State) (Zip)

Do you have any other insurance, including but not limited to group or individual health and/or accident, government plan, or automobile plan? YES ❑ NO ❑
If yes, please give name, address, phone number, and policy number of this plan. _____

AUTHORIZATION TO RELEASE INFORMATION

I authorize any Health Care Provider, Insurance Company, Employer, Person or Organization to release information regarding medical, dental, mental, alcohol or drug abuse history, treatment or benefits payable, including disability or employment related information, to Summit America Insurance Services, L.C., the Plan Administrator, or their employees and authorized agents for the purpose of validating and determining benefits payable. A photo copy of this authorization shall be as valid as the original.

Signature _____ Date _____

AUTHORIZATION TO PAY PROVIDER

I authorize payment of charges associated with this incident directly to the physicians or providers. I further certify that the foregoing information is true and correct.

Signature _____ Date _____

TO BE COMPLETED BY ADMINISTRATOR

NAME OF GROUP POLICYHOLDER | POLICY NUMBER

ADDRESS OF POLICYHOLDER

TELEPHONE NUMBER OF POLICYHOLDER

I certify that the foregoing information is true and correct.

Authorized Signature _____ Date _____

Title _____

Email Claims to: KK.PAClaims@kandkinsurance.com
Fax Claims to: 312-381-9077

The First Health Network

HYGEIA

IMPORTANT NOTICE
This plan of insurance is secondary to any health insurance you have. Submit your claim to your primary health insurance company first. When you receive an Explanation of Benefits Statement, send it along to us with our itemized bill and this completed form.

Payment will be made to the providers of service (Hospital, Physician or Others), unless a paid receipt statement accompanies the bill at the time the claim is submitted.

FRAUD STATEMENTS

The following fraud language is made part of and cannot be removed from this claim form. Please read thoroughly.

** **Alaska:** A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

** **Arizona:** 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.

** **Arkansas or Louisiana:** 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.

** **California:** 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.

** **Colorado:** 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.

** **Delaware:** Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

** **District of Columbia:** 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:** 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.

** **Idaho:** Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

** **Indiana:** A person who knowingly and with intent to defraud an insurer, files a statement of claim containing any false, incomplete, or misleading information, commits a felony.

** **Kentucky:** Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

** **Maine, Tennessee or Virginia:** 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 a denial of insurance benefits.

** **Minnesota:** A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

** **New Hampshire:** 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, as provided in RSA 638:20.

** **New Jersey:** Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

** **New Mexico:** 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.

** **New York:** 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. (PURSUANT TO 11 NYC RR86)

** **Ohio:** 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.

** **Oklahoma:** 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.

** **Pennsylvania:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

** **Puerto Rico:** Any person who knowingly, and with intent to defraud or deceive any insurance company includes false information in an application for insurance or files, assists, or abets in the filing of a fraudulent claim to obtain payment of a loss or other benefits, or files more than one claim for the same loss or damage, may be guilty of a felony. Upon conviction, that person will be fined between $5,000 and $10,000, imprisoned for three (3) years or both. Aggravating or attenuating circumstances may result in the prison term being increased to five (5) years or reduced to two (2) years.

** **Texas:** 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.

** **If you live in a state other than mentioned above, the following statement applies to you:**
Any person who knowingly, and with intent to injure, defraud or deceive any insurer or insurance company, files a statement of claim containing any materially false, incomplete, or misleading information or conceals any fact material thereto, may be guilty of a fraudulent act, may be prosecuted under state law and may be subject to civil and criminal penalties. In addition, any insurer or insurance company may deny benefits if false information materially related to a claim is provided by the claimant.

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On behalf of Nationwide Mutual Insurance Company
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PHONE NUMBER | DATE OF BIRTH | MALE ❑ FEMALE ❑

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____ INTRAMURAL SPORT ____ INTERSCHOLASTIC SPORT

DESCRIBE FULLY HOW AND WHERE THE INJURY OCCURRED _____

PARENT/GUARDIAN NAME (Last Name) (First Name) (Middle Initial)

ADDRESS (Street) (City) (State) (Zip)

Do you have any other insurance, including but not limited to group or individual health and/or accident, government plan, or automobile plan? YES ❑ NO ❑
If yes, please give name, address, phone number, and policy number of this plan. _____

AUTHORIZATION TO RELEASE INFORMATION

I authorize any Health Care Provider, Insurance Company, Employer, Person or Organization to release information regarding medical, dental, mental, alcohol or drug abuse history, treatment or benefits payable, including disability or employment related information, to Summit America Insurance Services, L.C., the Plan Administrator, or their employees and authorized agents for the purpose of validating and determining benefits payable. A photo copy of this authorization shall be as valid as the original.

Signature _____ Date _____

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Signature _____ Date _____

TO BE COMPLETED BY ADMINISTRATOR

NAME OF GROUP POLICYHOLDER | POLICY NUMBER

ADDRESS OF POLICYHOLDER

TELEPHONE NUMBER OF POLICYHOLDER

I certify that the foregoing information is true and correct.

Authorized Signature _____ _____ Date _____

Title _____ _____

Email Claims to: KK.PAClaims@kandkinsurance.com
Fax Claims to: 312-381-9077

The First Health Network

HYGEIA

To be completed by participant or parent of participant

To be completed by participant or parent of participant

To be completed by participant or parent of participant

To be completed, signed and dated by the authorized reprsentative.

Email Claims to: KK.PAClaims@kandkinsurance.com
Fax Claims to: 312-381-9077