PROOF OF CLAIM

Student Accident Insurance Plan

Mail completed form to:
Northwestern Scholastic Insurers
Box 256
Helena, MT 59624
406/458-5902

This form must be completed and submitted to the Company within 90 days from date of injury.

CLAIM PROCEDURE:

1. A school official must complete PART A.
2. The Insured's parents or guardian must complete PART B.
3. THE ATTENDING PHYSICIAN'S STATEMENT (back) should be completed by the doctor.
4. Attach doctor bills for medical services.
5. Attach hospital bills for services.
6. **Send completed claim form, doctor bills, and hospital bills to NORTHWESTERN SCHOLASTIC INSURERS**

PART A: NOTICE OF INJURY

1. Name of School _____ School District Name _____

   School Address _____
   (City) (State) (Zip)

2. Name of Insured _____ Grade _____ Age _____

3. Date of Injury _____ [ ] AM [ ] PM

4. Under whose supervision? _____ Was he/she a witness? _____

5. The accident was incurred while the Insured was participating in:

INTERSCHOLASTIC SPORTS

( ) Practice What Sport?
( ) Game
( ) Travel _____

NON-INTERSCHOLASTIC SPORTS

( ) Travel to/from school ( ) Non-school activity
( ) In classroom ( ) Other - Activity?
( ) Physical Education
( ) On school grounds _____

6. How did the accident happen? _____

_____

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

PART B: PARENT STATEMENT

***Part A may be completed by the parent if Full-Time Coverage was purchased.**

The student accident insurance plan is designed to offer maximum financial protection at a minimum cost. In order to maintain this balance of cost and adequate protection, the plan does not allow us to provide benefits for certain losses that are collectible from your personal insurance. This provision has greatly reduced the cost to you by not duplicating coverage that you already have in effect. Please attach a statement from your insurance company indicating what benefits are available and complete the following questions.

1. Parents Name _____ Relationship to Insured _____

   Address _____
   (Street or Route) (City) (State) (Zip)

2. Home phone number _____

3. Father's Occupation _____ Employer _____

   Mother's Occupation _____ Employer _____

4. ☐ Yes, I have personal insurance. See below.
   ☐ No, I don't have personal insurance.
   Name of Insurance Company _____ [ ] Group [ ] Individual Policy No. _____

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

5. Do you understand that you must furnish, with this claim, a statement from your personal insurance company indicating their allowable benefits or their reason for refusal to pay. Your claim will be held pending receipt of this information. [ ] Yes [ ] No

I hereby authorize any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance company, or other organization, institution, or person that has any records or knowledge of the claimant's physical or mental health, to give the information to NORTHWESTERN SCHOLASTIC INSURERS. To facilitate rapid submission of such information, I authorize all said sources, to give such records or knowledge to any agency employed by the insurance company to collect and transmit such information. A photocopy of this authorization shall be as valid as the original.

_____ _____
(Date) (Signature of Parent or Guardian)

THE BENEFITS ARE PAYABLE FOR ONE YEAR FROM THE DATE OF THE INJURY. MEDICAL TREATMENT MUST COMMENCE WITHIN 30 DAYS FROM THE DATE OF ACCIDENT.

ATTENDING PHYSICIAN'S STATEMENT

Attention Doctor and/or Dentist

Please be sure all information requested below is completed including your itemized bill, dates and types of treatments performed. Indicate if you have received payment by patient (or parent) for your charges.

Patient's name and address	Age

Diagnosis and concurrent conditions. (If fracture or dislocation, describe napture and location.)	
When did symptoms first appear or accident happen?	Date _____ , 20 _____
When did patient first consult you for this condition?	Date _____ , 20 _____
Describe any other disease or infirmity affecting present condition.	
Has patient ever had some or similar condition? If "Yes" state when and describe.	Yes [ ] No [ ]
Nature of surgical procedure, if any. (Describe fully.) Charge to patient for this procedure including postoperative care. If performed in hospital, give name of hospital.	Date performed _____ , 20 _____ $ _____ Inpatient [ ] Outpatient [ ]
Give dates of other medical (nonsurgical) treatment, if any.	Office _____ $ _____ Home _____ $ _____ Hospital _____ $ _____ Total (nonsurgical) _____
Is patient still under care for this condition? If "No" give date your services terminated.	Yes [ ] No [ ] Date _____ , 20 _____
Have you treated this patient for any condition prior to the date of the accident?	Yes [ ] No [ ]
To your knowledge does patient have other health insurance or health plan coverage?	Yes [ ] No [ ] If "Yes" identify

ADDITIONAL INFORMATION FOR DENTAL INJURY.

Identify injured teeth by tooth No. _____

Previous condition of injured teeth:

[ ] Whole, sound, natural; [ ] Filled;
[ ] Decayed; [ ] Root canal treated (Describe material, etc.)
[ ] Other _____

_____
TAX ID NO. OR S.S. NO.

DATE PHYSICIAN'S NAME (PRINT) SIGNATURE DEGREE

STREET ADDRESS CITY AND STATE ZIP CODE TELEPHONE