BOY SCOUTS OF AMERICA

EXPLORING™
DISCOVER YOUR FUTURE

**1. Please fully complete this claim form.**

**2. Attach itemized bills (UB04 or HCFA 1500 form)**

**3. Mail, fax or email to Health Special Risk, Inc.**
**E-Mail: boyscouts@hsri.com**

HSR
ACCIDENT INSURANCE SOLUTIONS
8400 Belleview Drive, Suite 150
Plano, Texas 75024
Payor ID# 65449
Toll Free 866-726-8870
Fax 972-512-5820
Underwritten by: ACE American Insurance Company

**Council Name:** _____

**Address:** _____

**City, ST, Zip:** _____

**Telephone Number:** _____

## PART 1 - BSA Council Representative Statement

**Check One:** ☐ Cub Scout ☐ Scouts BSA ☐ Venturer ☐ Sea Scout ☐ Leader ☐ Explorer ☐ Advisor
☐ Learning for Life – Curriculum Based ☐ Off Duty Volunteer Seasonal Staff ☐ Committee ☐ Family Member
☐ Other _____

| Pack, Troop, Post, Crew or Ship # | 1. Claimant's Name (Injured/Sick Person) | 2. Gender ☐ M ☐ F | 3. Date of Birth / / |
|---|---|---|---|

4. Claimant's Address (Street, City, State, Zip Code) and best contact telephone number (include area code)

| 5. If applicable, parent or legal guardian's name, address and best contact telephone number (include area code) | 6. E-Mail |
|---|---|

| 7. What date did accident occur or sickness begin? | 8. Nature of injury or sickness (indicate part of body injured – such as broken arm, sprained ankle, etc.) |
|---|---|

9. Describe how accident occurred – give details  Did Injury Result in Death? ☐YES ☐NO

| 10. Name of event or activity | 11. Name and title of adult Leader/ Advisor |
|---|---|

| 12. **Signature of Council representative** **X** | 13. Title | 14. Date |
|---|---|---|

## PART 2 – Other Insurance Statement

Do you/spouse/parent have medical/health care or is the Claimant enrolled as an individual, employee or dependent member of a Health Maintenance Organization (HMO) or similar prepaid health care plan, or any other type of accident/health/sickness plan coverage through your employer or other source on you or does your son/daughter have health care coverage as a dependent from your previous marriage as mandated in a divorce decree? ☐YES ☐NO

If Yes, name of insurance company _____ Policy #_____

Name of second insurance company _____ Policy #_____

### Coverage is Excess of All Other Insurance or Healthcare plans in Force

**This policy is excess to any and all other available source of medical insurance or other healthcare benefits. You must file your bills through your primary/personal insurance carrier or healthcare plan prior to this policy responding. When your primary insurance company or healthcare plan processes the charges, they will send you an Explanation of Benefits, or "EOB." Please submit copies of their Explanation of Benefits along with your claim to Health Special Risk, Inc. In the event you have no other primary insurance or healthcare plan, this policy with pay as primary subject to the plan limits and terms.**

**Please read & sign below: I agree that should it be determined at a later date there is insurance (or similar), to reimburse *HEALTH SPECIAL RISK, INC.*, or the insurance company to the extent of any amount collectible.**

**New York Fraud Warning Notice: 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 material 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.**

| **Signature of participant, parent or legal guardian** **X** | Date |
|---|---|

**NOTE: 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 or 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.**

### Authorization to pay benefits to provider

I authorize medical payments to physician or supplier for services described on any attached statements enclosed. (If not signed submit proof of payment)

**Signature X**_____ **DATE** _____

### Authorization for release of information

I hereby authorize any insurance company, hospital, physician 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, consultation, prescription or treatment, and copies of all hospital or medical records. A photostatic copy of this authorization shall be considered as effective and valid as the original.

**Signature X**_____ **DATE** _____

**By entering your name above, you are signing this claim form electronically. You agree your electronic Signature is the legal equivalent of your manual/handwritten signature on this claim form.**

## FRAUD WARNING NOTICES

Any person who knowingly presents a false of fraudulent claim for payment of 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.

## STATE SPECIFIC PROVISIONS

| | |
|---|---|
| **Alabama** | Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof. |
| **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**<br>**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 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 for insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies. |
| **Connecticut** | This form must be completed in its entirety. Any person who intentionally misrepresents or intentionally fails to disclose any material fact related to a claimed injury may be guilty of a felony. |
| **Delaware**<br>**Idaho** | 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 containing any false, incomplete, or misleading information is guilty of a felony of the third degree. |
| **Hawaii** | For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both. |
| **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** | 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 denial of insurance benefits. |
| **Maryland** | Any person who knowingly and willfully presents a false or fraudulent claim for payment of<br>a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. |
| **Michigan**<br>**North Dakota**<br>**South Dakota** | Any person who knowingly and with intent to defraud any insurance company or another 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 and subject the person to criminal civil penalties. |
| **Minnesota** | A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime. |
| **Nevada** | Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty o f a criminal act punishable under state or federal law, or both and may be subject to civil penalties. |
| **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 includes any false or misleading information on an application for an insurance policy 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. |
| **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. |
| **Oregon** | Any person who knowingly and with intent to defraud or solicit another to defraud an insurer: (1) by submitting an application, or (2) by filing a claim containing a false statement as to any material fact thereto, may be committing a fraudulent insurance act, which may be a crime and may subject the person to criminal and civil penalties. |
| **Pennsylvania** | 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. |
| **Rhode Island**<br>**West Virginia** | 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. |
| **Tennessee**<br>**Virginia**<br>**Washington** | 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. |
| **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. |
| **Utah** | Any person who knowingly presents false or fraudulent underwriting information, files or causes to be filed a false or fraudulent claim for disability compensation or medical benefits or submits a false or fraudulent report or billing for health care fees or other professional services is guilty of a crime and may be subject to fines and confinement in state prison. Utah Workers Compensation claims only. |

## HOW TO SUBMIT A CLAIM

### Listed below are important instructions and comments about filing a claim.

### YOUR CLAIM FORM

1. This claim form should be fully complete and submitted within 90 days from the date of injury. Be sure to answer and complete the section regarding **"OTHER INSURANCE STATEMENT"**, marking either yes or no and signing the line for authorization so that ***HSR*** and the doctors/hospitals may communicate concerning your claim.
   **Incomplete claim forms are one of the most frequent reasons why claim payments are delayed.**
2. The claim form must be signed by a policyholder representative (i.e. council, leader).
3. Only one claim form for each accident needs to be submitted.
4. Once completed, make a photocopy for your records and mail to the address shown below.
5. **DO NOT** assume that anyone else will mail this claim form to ***HSR*** for you.

### YOUR BILLS

1. Please advise all doctors/hospitals regarding this coverage so they may forward their itemized bills to us.
2. If you have already been to the doctor/hospital and did not know about this coverage, please send all of the itemized bills you receive to ***HSR*** at the address shown below.
3. The bills should include the name of the doctor/hospital, their complete mailing address, telephone number, the date you were seen by the doctor/hospital, what the doctor saw you for (diagnosis) and the specific itemized charges incurred (description of treatment including the CPT/procedure code). Contact your medical provider for a UB04 or HCFA 1500 billing form.
4. Due to HIPAA Privacy laws ***HSR*** is unable to request this information from your medical provider. Ultimately, it is your responsibility to provide the proper documentation. "Balance Due" or "Balance Forward" statements do not contain sufficient information to complete your claim. ***HSR*** cannot pay your bills using only the Primary Insurance Carrier's EOB.

### EXCESS INSURANCE

**The policy is excess to any other available source of medical benefits**. This means that you must file your bills through your primary, or personal, insurance carrier prior to this policy responding**.** When your primary insurance company processes the charges, they will send you an Explanation of Benefits, or "EOB". You must forward a copy of the Explanation of Benefits for EACH CHARGE.

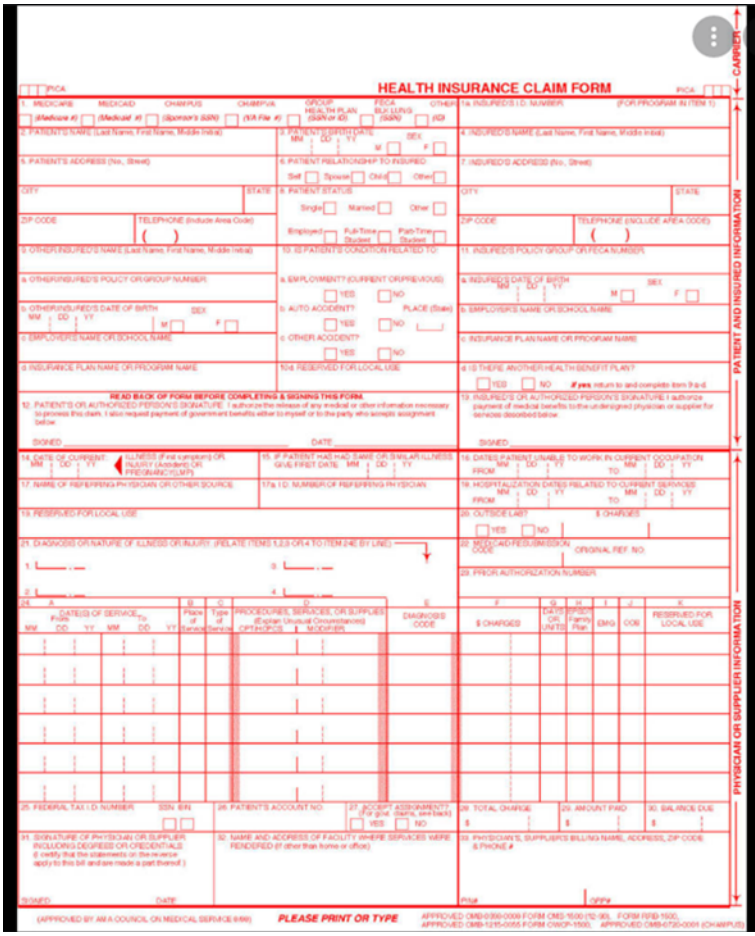
If you have any questions, please contact Customer Service from 8:00 AM to 5:00 PM, Monday – Friday at **(866) 726-8870** or via e-mail at **boyscouts@hsri.com**. You may also forward any documents by fax to (972) 512-5820.

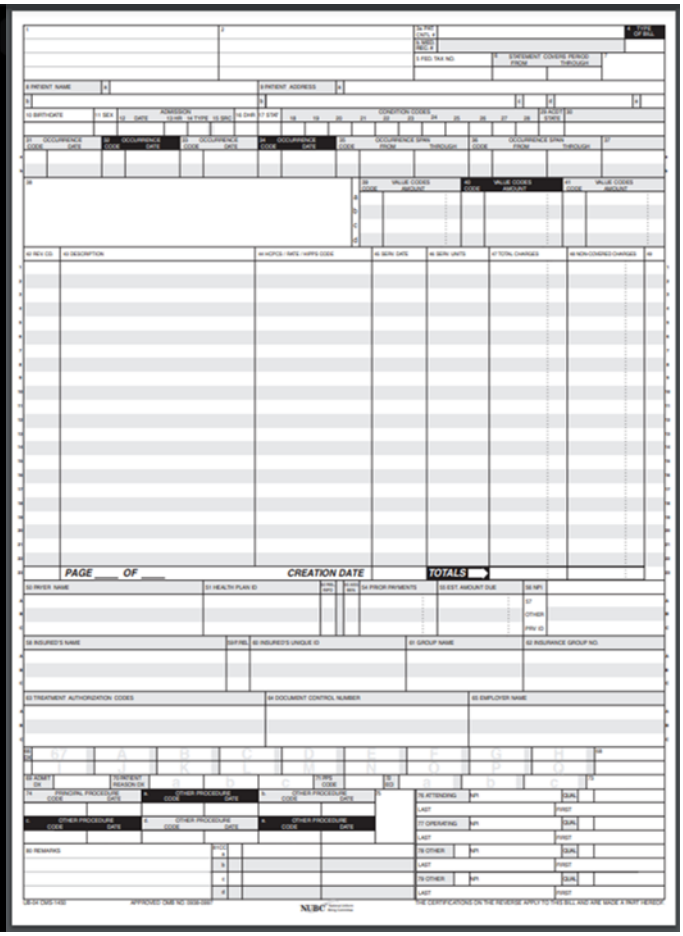
***Health Special Risk, Inc.***
**8400 Belleview Drive, Suite 150**
**Plano, Texas 75024**

**What is an Itemized Bill?**

An itemized bill is a full detailed listing of all actual charges that a patient or their primary insurance is being billed for based on the care received. Typically, these come in the form of a HCFA-1500 for physician services or UB04 for facility charges. See below examples.

***Sample CMS HCFA Billing*** ***Sample UB04 Billing***



***Sample CMS HCFA Billing*** ***Sample UB04 Billing***