How to File a Medical Claim
Bene-Marc Texas Student Accident Insurance Program

Policy Year 08/01/2009 - 08/01/2010
(52 Week Benefit Period; 1st expense incurred within 26 weeks of accident)

Attached is a Blanket Lines Notice of Claim (Claim Form) for your accident policy.
Please forward claims and questions to the following address:

Fringe Benefit Coordinators, Inc.
P. O. Box 5249, Gainesville, FL 32627-5249
Toll Free Number (800) 654-1452
Fax Number (352) 372-9805

Step 1 - Submit a completed Notice of Claim (claim form) to our office either by fax or mail

The Policyholder's School Official/Trainer (not the Parent, Claimant or Agent) should:

- In the Policyholder Certification section of the form, fully answer each question and sign the Policyholder Certification Statement.

The Parent/Guardian (not the Policyholder or Agent) should:

- In the Claimant Certification section of the form, fully answer each question and sign the Parent/Guardian Certification Statement.

Step 2 - Submit itemized medical bills for payment consideration to our office. This policy was issued on an Excess basis, so please also include any other insurance carrier's corresponding Explanation of Benefits (EOBs), as outlined in the helpful information bullet listed below.

Helpful information for submitting claims and expediting payment

- A complete Notice of Claim is required for each accident/injury a Claimant incurs.
- Proof of Lost must be submitted within 90 days.
- Providers may wish to bill us directly for their services. If they do, please ensure a Notice of Claim has first been submitted to our office.
- Itemized medical bills (including claimant name, date of service, diagnosis, procedure codes, amount charged, and provider information) should be submitted for processing. "Balance Due" statements and/or incomplete bills do not provide enough claim detail to process the charges. In order to ensure we receive complete claim information, we suggest providers submit standardized billing statements (called "UB-04" for hospital charges and/or a "CMS-1500" for physician charges).
- For Excess Policies, if the Claimant has other insurance coverage, medical bills should first be submitted to your other insurance carrier for payment. Once they have processed the charges (either paid or denied), then submit a copy of your provider's itemized medical bill and the other carrier's coordinating Explanation of Benefits (EOB) to our office for processing. Important - we are unable to make a claim determination without both of these items; claim payment will be expedited if the medical bill and EOB are the submitted at the same time.
- Unless proof of payment is submitted with the medical bill (a copy of check, a medical bill that indicates the claimant has made all or partial payment or zero balance information) claim payment is generally sent directly to the medical providers.

Please detach this page and forward the completed Notice of Claim (and medical bills if you are submitting expenses for payment) to the address listed above. We recommend you keep copies of the correspondence you are submitting to use for future reference.

HARTFORD LIFE & ACCIDENT INSURANCE COMPANY

Notice of Claim

Bene-Marc Texas Student Accident Insurance Program

Fringe Benefit Coordinators, Inc., P. O. Box 5249, Gainesville, FL 32627-5249
Toll Free Number (800) 654-1452 Fax Number (352) 372-9805

POLICYHOLDER CERTIFICATION - To be completed by School Official/Trainer

Policyholder Number	Policyholder Name (School District)	
School Name		School Official/Trainer Telephone Number ( )

Has Claimant elected voluntary coverage? ☐ Yes ☐ No If so, check all that apply
☐ 24 Hour ☐ School Time ☐ Extended Dental

Claimant (Injured Party) Name	Claimant Date of Birth	Claimant Telephone Number ( )

Claimant Address (Street Number, City, State, Zip)

Date of Accident (mm/dd/yyyy)	Time of Accident (hh:mm) _____ ☐ AM ☐ PM	Place of Accident	Field Trip ☐ Yes ☐ No

Cause of Accident:	Indicate injured body part(s)	Sport or Activity Type

Nature of sickness (if applicable)	Date sickness first commenced

Policyholder Certification Statement (Signature Required)

This Claimant is a member of the group insured under the above Policy and the injury/sickness was sustained under adequate supervision while participating in an official Covered Activity.

Texas law requires we advise you the following information regarding fraud. A person commits a fraudulent insurance act if that person knowingly and with intent to defraud any insurance company or person, either: (a) files an application for insurance or statement of claim containing any materially false information, or (b) conceals information concerning any material fact in order to obtain an insurance policy or a benefit under an insurance policy. A fraudulent insurance act is a crime. The Hartford shall pursue prosecution of any fraudulent insurance act to the fullest extent of the law.

I hereby certify the above statements made by and certified by me to be true to the best of my knowledge. I am aware that if any of the foregoing statements on this form made by me are willfully false, I may be subject to penalties, which may include criminal prosecution.

Title of Policyholder Official/Trainer _____ Signature of Policyholder Official/Trainer _____ Date _____

CLAIMANT CERTIFICATION - To be completed by Parent/Guardian

Does the Claimant have medical coverage through:

Mother's employers policy*	☐ Yes	☐ No
Father's employers policy*	☐ Yes	☐ No
Guardian's employers policy*	☐ Yes	☐ No
Medicare policy	☐ Yes	☐ No
Medicaid policy	☐ Yes	☐ No
Any other medical policy*	☐ Yes	☐ No

If yes, provide details: _____

*If yes, please include the other insurance carrier's Explanation of Benefits (EOBs) for each medical bill submitted.

Parent/Guardian Certification Statement (Signature Required)

I authorize any physician/hospital that has attended my dependent child to disclose information thus acquired for the purpose of this claim payment.

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I hereby certify the above statements made by and certified by me to be true to the best of my knowledge. I am aware that if any of the foregoing statements on this form made by me are willfully false, I may be subject to penalties, which may include criminal prosecution.

Printed Name of Parent/Guardian _____ Signature of Parent/Guardian _____ Date _____