Boy Scouts of America

1. PLEASE FULLY COMPLETE THIS FORM
2. ATTACH ITEMIZED BILLS WITH DOCTOR'S DIAGNOSIS
3. MAIL TO HEALTH SPECIAL RISK, INC.

E-Mail: boyscouts@hsri.com PTP N00327402

HSR
Health Special Risk, Inc.
HSR Plaza
4100 Medical Parkway
Carrollton, TX 75007-1517
Toll Free 866-726-8870
Fax 972-512-5820

To be completed by BSA Leader

Council Name: Sam Houston
Address: P.O. Box 924528
Houston, TX 77292
Telephone Number: 713-659-8111

ACE American Insurance Company

FOR *HSR* USE ONLY: Claim Company # _____ Plan # _____ Location # _____

PART 1 - BSA Leader's Statement

Check One: ☐ Tiger Cub ☐ Tiger Cub Adult ☐ Varsity Scout ☐ Cub ☐ Scout ☐ Venturer ☐ Leader ☐ Committee ☐ Learning for Life – Explorer ☐ Paid Seasonal Staff ☐ Volunteer Seasonal Staff ☐ Other _____

Check Policy: ☒ Council ☐ Unit ☐ Campers & Special Events ☐ National Events

Pack, Troop, Post, or Team Number	1. Claimant's Name (Injured/Sick Person)	2. Social Security Number - -	3. Gender __M __F	4. Birthday ___/___/___
Troop 957				

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

6. If applicable, parent's name, address and best contact telephone number (include area code)	7. E-Mail

8. What date did accident happen or sickness begin?	9. Nature of injury or sickness (indicate part of body injured – such as broken arm, sprained ankle, etc.)

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

11. Name of event or activity	12. Name and title of adult leader

13. **Signature of policyholder representative** X	14. Title	15. 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 Primary for First $300.00 Only, Then Excess

This policy is excess to any other available source of medical benefits if the charges are greater than $300.00. You must file your bills through your primary/personal insurance carrier prior to this policy responding. If the total charges are less than $300.00, we will pay without the other insurance coordination. When your primary insurance company 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.

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.

Signature of participant or parent X	Witness	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.

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** _____

ATTACH ITEMIZED BILLS WITH DOCTOR'S DIAGNOSIS

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 your for and the specific itemized charges incurred.
4. If this information is not on the bill when you send it to us, we will have to contact the doctor/hospital which will delay the review of your claim. "Balance Due" statements do not contain sufficient information to complete your claim. Mailing ***HSR*** "Balance Due" statements will only delay the processing of your claim.

EXCESS INSURANCE

The policy is excess to any other available source of medical benefits if the charges are greater than $300.00. This means that you must file your bills through your primary, or personal, insurance carrier prior to this policy responding. **If the total charges are less than $300.00, we will pay without the other insurance coordination.** 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 thru 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.
4100 Medical Parkway
Carrollton, TX 75007