

SCHOOL INSURANCE CLAIM FORM
CLAIM FORM AND NOTICE OF INJURY TO BE MAILED TO:
SCHOOL INSURANCE OF FLORIDA, P.O. BOX 784268, WINTER GARDEN, FLA. 34778-4268

The underwriting insurance company is Reliance Standard Life Insurance Co. Schaumburg, IL.

PARENTS: Policy limitations and exclusions are on the take home summary of insurance brochure. The Policy does not pay 100% of billed expense. It is the parent/guardian's responsibility to ask Doctors and Providers what remaining balances you may be required to pay regarding this claim, if any. This is **'Excess Insurance'**. You **MUST** file a claim with your primary insurance first. **A school Official is required to fill out PART B only if the injury is school related.** This form cannot be processed unless all questions are answered below and all signatures are in place. It is the duty of the claimant, (Parent/Legal Guardian), to furnish the company with itemized bills, explanation of primary insurance benefits paid, and this form completed. Visit School Insurance of Florida . Com for information regarding where to seek treatment and claim filing instructions. **THIS CLAIM FORM MUST BE FILED WITHIN 90 DAYS AFTER DATE OF ACCIDENT.** The policy allows for bills to be sent in for up to one year from the date of accident. **PLEASE DO NOT LEAVE THIS FORM WITH YOUR PHYSICIAN OR HOSPITAL.** It is the parent/guardian's responsibility to ask Doctors/ Providers what remaining balances you may be required to pay regarding this claim, if any.

PART A: PARENT/GUARDIAN MUST COMPLETE AND SIGN PART A. Please print your answers.

1. Name of School: _____ County: _____ Grade: _____

2. Last Name of Student: _____ First Name: _____ Middle Initial: _____

3. Mailing Address of Parent: _____ City: _____ State: _____ Zip: _____

4. Home Phone # () - _____ Date of Birth / / _____

5) WE CANNOT PROCESS THIS CLAIM UNLESS YOU GIVE US A DETAILED DESCRIPTION OF HOW, WHEN AND WHAT OCCURRED, THAT CAUSED THE INJURY. (Use back of this form if more space is needed). How? What? When? Be specific please.

6. **INJURY DATE:** Month _____ Day _____ Year _____ Time _____ AM or PM - Where did the accident happen? _____

If this is sports related what is the name of the team or camp? _____

7. Nature of Injury or sickness (indicate part of body injured-such as broken arm, sprained ankle etc...) _____

8. **NAME OF ANY OTHER INSURANCE** that may provide benefits for this injury. (If none, say none. Do not leave this line blank). _____

Other insurance includes but is not limited to the following: HMO's, PPO's BC/BS, United, Employer Benefits, ERISA, Medicaid, Welfare or Government Trust accounts, or Tri-care. **It is the parent/guardian's responsibility to ask Doctors and Providers what remaining balances you may be required to pay regarding this claim, if any. This policy will not pay for 100% of billed charges.** What is deductible or co-pay (if any)? \$ _____

If you have a Medicaid plan please send a copy of your insurance card with this form.

9. Address of claims office of insurance company on line 8. _____

10. Mother's Name and Employer: _____ Occupation: _____

Mother's Employer Address: _____ Telephone # _____

11. Father's Name and Employer: _____ Occupation: _____

Father's Employer Address: _____ Telephone # _____

*****The above answers are true and correct. I hereby authorize any person or institution to release any information requested by the insurance company or its agent to them, including history and physical, diagnosis or other medical or insurance information. A photo static copy of this authorization shall be considered as effective and valid as the original. FLORIDA LAW: "Any person who knowingly and with intent to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony of third degree."**

PARENT/
12. GUARDIAN SIGN HERE: _____ Today's Date: ____/____/____ Print Name: _____

PART B - Must be filled out and signed by a School Official for ALL school sports related injuries. Must be filled out for all other school related injuries unless the student purchased the 24 Hour Plan.

1. WE CANNOT PROCESS THIS CLAIM UNLESS YOU GIVE US A DETAILED DESCRIPTION OF HOW THE ACCIDENT OCCURRED THAT CAUSED THE INJURY. Please be specific. (Use back of this form if more space is needed.)

2. Injury Date: Month _____ Day _____ Year _____ Time _____ AM or PM Part of body injured (include whether right or left) _____

3. At the time of the injury was the student involved in a school sponsored, funded, scheduled and supervised activity? YES NO

Please select or list the interscholastic sport or activity the student was participating in. Circle One.

P.E. Class - Football Game - Football Practice - Soccer - Volleyball - Baseball - Softball - Track - Wrestling - Flag Football - Competitive Cheerleading - Rugby Lacrosse-- Side line Cheerleading - Basketball OTHER LIST _____

4. Under whose supervision(witness)? _____ What date has the Athlete returned to play if applicable? ____/____/____

5. Print Name of School Official _____ School phone Number: _____ - _____ - _____

6. Original Signature of School Official _____ (Only if injury is School Related) Today's Date: ____/____/____

Please DO NOT LEAVE THIS FORM with the Doctor or Hospital. Mail to School Insurance of Florida immediately upon completion.

PLEASE FOLLOW THESE INSTRUCTIONS TO FILE A CLAIM

- 1) You must file your claim with your other (Primary) insurance company first. Other insurance include, but not limited to: HMO's, PPO's BC/BS, United, Employer Benefits, HSA's or Tri-care. ***This is secondary coverage*** and may not pay for 100% of medical expenses incurred. When your claim has been processed by your primary insurance; mail a copy of the explanation of benefits (EOB's), the itemized bills to *School Insurance of Florida*. **We cannot accept a balance due statement, itemized bills are required.** ***Important note:*** Please do not leave the claim form with the Hospital or Doctor's Office. Participants can seek treatment from any licensed provider of service. **It is the participants responsibility to find out what out of pocket expenses they could incur. Please ask your provider of service if they are in your primary network. Visit School Insurance of Florida .Com for provider information.**

- 2) **A completed School Insurance of Florida Claim Form must be submitted within 90 days from the date of the incident.** If the condition is school related or happened at school Part B must be completed. If the condition did not happen at school complete Part A and mail directly to School Insurance of Florida. For additional information please contact School Insurance of Florida 1-800-432-6915.

- 3) The plan administrator mailing address is: **School Insurance of Florida**
P.O Box 784268
Winter Garden, FL. 34778-4268

Reasons claims are delayed for processing: 1. Claim Forms Not Completed In Full or Not Submitted. 2. Balance Due Statements, Balance Forward Statements, or Past Due Statements submitted instead of the correct Medical Itemized Bills (UB-04/92 or HCFA-1500) which are standard forms used by providers of service or Doctors. 3. Explanation of Benefits from Primary Insurance Carrier not provided with the correct bills.

If we do not receive your reply within 45 days, we will close our file. However, upon receipt of the requested information, we will reopen the file and process your claim in accordance with the policy provisions.

ADDITIONAL
COMMENTS: _____

School Board of Orange County, Florida

Student Accident Insurance Summary and Claim Form

IMPORTANT NOTICE FOR SCHOOL AGE CARE / EXTENDED DAY ENRICHMENT STUDENTS AND

CBVE STUDENTS: Your school is very interested in providing a safe environment for all students. However, accidents do happen every day during school activities. Therefore, the School Board of Orange County, Florida provides a basic accident insurance policy for School Age Care/Extended Day Enrichment participants. We strongly urge all parents to read this description of coverage in case an accident occurs. This policy may not pay for 100% of all medical expenses due to the limits of the policy as described below.

The policy ensures participants during CBVE and School Age Care/Extended Day Programs that are exclusively scheduled/sponsored/funded by OCPS, or an outsourced third-party entity designated by OCPS to provide direct supervision of School Age Care/Extended Day Enrichment program participants and for Community Based Vocational Education students that are supervised by a District designated employee. The School Age Care/Extended Day Enrichment participants are also protected during group travel in a school bus or van during travel to and from the school premises and a covered activity. Injuries sustained during travel in vehicles that are not owned, leased or operated by OCPS are not covered by the OCPS policy.

The policy is EXCESS INSURANCE. The policy will not allow anyone to profit by collecting duplicate benefits from several insurance sources. Any benefits that could be collected from any other insurance, PPO, HMO or other available source of coverage must pay first before parents are able to collect benefits from the OCPS School Age Care/Extended Day policy. If primary HMO or PPO coverage is available through your employer-sponsored plan, you should use the HMO or PPO approved doctors, hospitals and other providers for treatment of your child's injuries. A parent must file a claim with any primary insurance coverage available. If you do not follow the guidelines of your HMO or PPO primary insurance networks, you will be solely responsible for paying any unpaid medical bills, or additional costs you may incur, that are not covered by the School Age Care/Extended Day policy.

COVERED ACCIDENTS: This policy may provide benefits for covered claims only due to accidental injuries. A 'covered accident' is defined as a sudden, unforeseen, unexpected identifiable single event which results in accidental bodily injury to a covered School Age Care/Extended Day and CBVE participants, independent of all other causes, occurring while the school policy is in force. Prolonged over-exertion or repeated injury due to non-accidental overuse is not considered a "covered accident".

SURGERY as defined in the policy means (a) the repair of a laceration that requires sutures (b) any cutting operation, or (c) the reduction of a fracture or dislocation; (treatment of a non-displaced fracture not requiring reduction is not considered a surgical procedure).

PREFERRED PROVIDER NETWORK is a listing of medical service providers, doctors and out-patient facilities, who have agreed to accept the school policy benefits as payment in full for services rendered in most cases. It is the parent's responsibility to pay any charges that are not covered by the school insurance plan. Not all doctors and hospitals accept the school insurance policy benefits as payment in full for services rendered. Go to Schoolinsuranceofflorida.com for a listing.

NO PROFIT CLAUSE: The policy is EXCESS INSURANCE. This means that any benefit payments that could be collected from any other insurance or similar plan must pay first. (If a person fails to follow rules of a PPO or HMO type plan and loses benefits that could have been collected, these benefits will be classified as collectible and the school insurance policy benefits will be reduced by the amount that could have been collected from the HMO or PPO). Total payment by all collectible insurance or plans shall never exceed the total reasonable medical expense incurred.

<Please refer to additional terms, limits and information on the next page>

SCHOOL INSURANCE OF FLORIDA

P.O. BOX 784268

WINTER GARDEN, FL 34778

Local Phone: 407-798-0290 or 800-432-6915 FAX: 407-798-0296

OCPS 2023

The School Board of Orange County School Accident Insurance Summary

MAXIMUM POLICY LIMITS

The maximum medical benefits will not exceed \$25,000.00 per covered injury. The School Age Care/Extended Day and CBVE policy may not pay for all accident-related medical expenses. Some bills may exceed the limits of the policy. The maximum policy benefits are listed below. For a claim to be considered eligible for policy benefits, an injured student must receive medical treatment by a licensed physician within 30 days after the date of the original covered accident. The policy will pay for necessary, eligible medical treatment expenses that are rendered and billed within 52 weeks after the date of a covered accident subject to the following policy limits:

Inpatient Hospital Benefits: For daily Semi-Private Room & Board including all miscellaneous charges, supplies, services, operating room, implantable devices, etc., the policy pays up to \$2,000.00 per day; While in Intensive Care, including all miscellaneous charges, supplies, services, operating room, implantable devices, etc., the policy pays up to \$3,000.00 per day.

Outpatient Hospital, Emergency Room or Same-Day Surgi-Center Benefits: If outpatient major surgery is performed requiring general anesthesia, the policy pays up to \$6,500.00 for all hospital or Surgi-Center billed supplies, services and implantable devices; the policy will pay up to \$500.00 for use of the hospital's Emergency Room, (*Emergency Room benefit applies to injuries requiring emergency treatment within 72 hours of an accident*);

Physician's Non-Surgical Office or Hospital visits and Consultations: Initial non-surgical visit payable up to \$68.00; up to \$56.00 paid for necessary non-surgical follow-up visits; if a Consultation with a Specialist is required, the policy will pay up to \$116.00 for one visit to a Specialist.

Surgery Fees: Benefits for the primary surgeon are paid based upon the fee amounts stated in the 2008 Florida Work Comp Fee Schedule (Part A). **Assistant Surgeon's Benefit:** (when medically necessary) is payable up to 25% of the primary surgeon's allowable benefit.

Anesthesiology Administration Benefit: is payable up to 20% of the primary surgeon's allowable benefit.

Policy limits for X-Rays, MRI, CAT, other Scans and Lab (including interpretation and reading fees): All X-Rays: \$250.00; MRI, CAT and other SCANS: \$500.00 in the aggregate; Laboratory Expense: Up to \$150.00.

Outpatient Physical Therapy Treatment Visits: Limited to 10 visits per covered injury not to exceed \$40.00 per treatment visit.

Orthopedic Appliances: (When used for rehabilitation purposes): up to \$300.00.

Drug Store Prescriptions (when prescribed by an M.D. for a covered accident): Up to \$100.00.

Emergency Ambulance Service: Up to \$500.00 (Air or Ground)

Dental Services: (Amount payable per injured tooth (includes x-rays): up to \$500.00 for treatment of each injured tooth.

THE ACCIDENT INSURANCE POLICY DOES NOT COVER:

- 1) Injury caused by or while under the influence of alcohol or drugs unless prescribed by a licensed physician.
- 2) Treatment performed by anyone retained by the schools or by any member of a covered person's immediate family.
- 3) Injury caused by participation in any type of organized sports league or non-District sponsored/funded summer camps.
- 4) The existence or aggravation of a physical or mental infirmity, condition or disease, whether infectious, congenital, secondary or acquired in origin. Conditions or the aggravation of conditions that originated prior to the school policy Effective Date are not covered.
- 5) Any form of illness, sickness or disease including but not limited to the following: Perthes' Disease, Osgood-Schlatter's Disease, Osteomyelitis, Osteochondritis, Osteogenesis Imperfecta, Slipped Capital Femoral Epiphysis, Thrombophlebitis, Hysterical Reactions, Boils, Athlete's foot, impetigo or similar skin infection, rashes, poisonous vegetation reactions, warts, blisters, calluses, cramps, muscle spasms, allergies or allergic reactions, ingrown nails, appendicitis, infections occurring other than as a result of such injury, detached retina, or treatment expense for similar conditions not due to accidental bodily injury. Hernia, in any form regardless of cause, Mental illness, Psychiatric evaluation or treatment expense.
- 6) Injury occurring during travel between the School and the home premises of a covered person.
- 7) Expense resulting from participating in activities for which benefits would be payable, in the absence of this insurance, under any high school or association-sponsored catastrophe sports accident policy or trust fund is expressly excluded from coverage.
- 8) Motor Vehicle Injury expense is payable up to \$2,000.00 only after all other motor vehicle and other primary insurance sources have paid.
- 9) Any Expense for which a benefit is not listed in the policy schedule of benefits.

FOR ADDITIONAL INFORMATION CONTACT:

SCHOOL INSURANCE OF FLORIDA

P.O. BOX 784268

WINTER GARDEN, FL 34778

Local Phone: 407-798-0290 or 800-432-6915 FAX: 407-798-0296

OCPS 2023