Claim Form Instructions

SEND CLAIMS TO:

WebTPA
PO Box 2415
Grapevine, TX 76099-2415
866-975-9468

How to Complete a Claim Form - Page 1

Gerber Life Insurance Company

CLAIM FORM
SIGNED CLAIM FORM IS REQUIRED

1. PLEASE FULLY COMPLETE THIS FORM PAGE 1 & PAGE 2
2. ATTACH HCFA/UB04-MEDICAL BILLS & EOBS FROM ANY OTHER INSURANCE YOU HAVE
3. SEND ALL CORRESPONDENCE TO:

WEB-TPA
P.O. Box 2415
Grapevine, TX 76099-2415

Toll-Free: 866-975-9468
Fax: 469-417-1969
Email: benefit.assist@webtpa.com

IMPORTANT NOTICE:
This plan of insurance is secondary, in most instances, to any health insurance you have. If you have other insurance, submit your claim (health and/or dental) to your other insurer. When you receive their Benefit Statement, send it to us along with your HCFA/UB04 (medical bills) and this completed form. Note: **The accident policy benefits are limited and may not provide 100% coverage.**

IF PART 1-A & PART 1-B ARE NOT COMPLETED IN FULL THIS CLAIM CANNOT BE PROCESSED AND WILL BE RE...

PART 1-A – TO BE COMPLETED IN FULL BY THE ORGANIZATION/SCHOOL

Organization/School District/College Name ______ Policy Number ______

School/Team/League Name ______ Phone No. ( ) ______

Address ______ Email ______

______ Type of Activity/Sport ______

If Athletics, designate ☐P.E. Class ☐Intramural ☐Interscholastic ☐Intercollegiate ☐Game ☐Jr. Varsity ☐Varsity ☐Youth ☐Adult ☐Practice ☐Other ______

Name of injured person/student ______

Date of Accident ______ Accident Time ______

Date of First Treatment ______ Has treatment been completed? ☐Yes ☐No

Where and how did accident occur? (Please be specific) ______

Part of body Injured ______ ☐Right or ☐Left At the time of the accident, was the claimant involved in a sponsore[d] and supervised activity and were they a current student/member of the Organization/School District? ☐Yes ☐No

Under whose supervision? ______ Was he/she a witness? ☐Yes ☐No

Authorized Signature ______ Title ______ Date ______

(MUST BE SIGNED BY AN ORGANIZATION/SCHOOL OFFICIAL UNLESS INJURY DID NOT OCCUR DURING AN ORGANIZATION/SCHOOL ACTIVITY. SIGNATURE IS REQUIRED)

PART 1-B – TO BE COMPLETED IN FULL BY CLAIMANT – OR BY PARENT/LEGAL GUARDIAN IF CLAIMANT IS A MINOR

Injured Party/Student Legal Name ______ Preferred/Nickname: ______

Date of Birth ______ Age ______ Grade Level ______ ☐Male ☐Female

Claimant is a ☐Student ☐Player ☐Coach ☐Official/Umpire ☐Volunteer ☐Child Care ☐Participant ☐CE Student (# of credits____)

Address of Injured Person or Parents/Guardian ______

Phone No. ( ) ______ Email Address ______

If Injured party is over age 18: Employer Name and Address ______

Phone No. ( ) ______ ☐Self Employed ☐Unemployed

Father/Guardian Name ______

Employer Name and Address ______ Phone No. ( ) ______

______ ☐Self Employed ☐Unemployed

PLEASE CONTINUE TO THE NEXT PAGE OF THE FORM WHICH MUST BE COMPLETED IN FULL

Part 1A should be completed by school representative.

If not filled in, enter school name and policy number.

Enter school address and email of contact person.

Enter information about accident that occurred and person injured, including type of sport and what claimant was doing.

School representative must sign and date.

Part 1B should be filled out by person who is injured (claimant) or parent/ guardian of claimant.

Enter claimant information, including name, DOB, gender, grade, address, and contact email address.

If claimant is employed, enter employer information (even if accident did not occur at work).

Enter Father's or one Guardian's information, including employer name and address.

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Mother/Guardian Name ____

Employer Name and Address ______________________________ Phone No. (   )__________

______________________________ ☐Self Employed ☐Unemployed

> Enter Mother's or second Guardian's information, including employer name and address.

If Dental Injury: Please submit verification from the dentist that the tooth/teeth are whole, sound and natural.

> **If dental injury, attach documentation from dentist who treated injury.**

Is claimant covered under any other medical and or dental insurance policy? ☐Yes ☐No

Is claimant covered under a government sponsored insurance such as Medicare/Medicaid? ☐Yes ☐No

Name of all companies providing claimant insurance coverage or prepaid health plans

Name of Company	Address	Policy #

Are benefits due for this claim under these other insurance coverages? ☐Yes ☐No **(See IMPORTANT NOTICE at top of form on page 1)**

Does your son or daughter have medical insurance coverage as an eligible dependent from a previous marriage as mandated in a divorce decree? ☐Yes ☐No If yes, please give name, address and phone number of responsible party ______________________

> Enter information about all other insurance through employer(s), Medicare/Medicaid, or any other coverage.

AFFIDAVIT: I verify that the above statement on other insurance is accurate and complete. I understand that the intentional furnishing of incorrect information via the U.S. Mail may be fraudulent and violate federal laws as well as state laws. I agree that it is determined at a later date that there are other insurance benefits collectible on this claim I will reimburse Gerber Life Insurance Company to the extent for which Gerber Life Insurance Company would not have been liable.

Signature: Injured Person, Parent or Guardian ______________________________ Date: __________

SIGNATURE IS REQUIRED

> Signature of claimant, or parent/guardian if claimant is under 18 years old, is required.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize any employer, health plan, insurance company, hospital, physician, health care profession, clinic, laboratory, pharmacy, medical facility or other person that has provided treatment, payment, or services in connection with this claim to disclose, when requested to do so, all information with respect to any injury, policy coverage, medical history, consultations, prescription or treatment, and copies of all hospital or medical records and itemized bills to WebTPA, Inc. and Gerber Life Insurance Company, it's agents, employees and representatives.

I hereby authorize WebTPA, Inc. to discuss any information related to medical expenses incurred or treatments rendered in connection with this claim, with Special Markets Insurance Consultants, Inc. representatives and their assigned agents and to officials at the school or organization through which this policy is issued. A photo static copy of this authorization shall be considered as effective and valid as the original.

Signature: Injured Person, Parent or Guardian ______________________________ Date: __________

> 2nd Signature of claimant, or parent/guardian if claimant is under 18 years old, is required.