

PLEASE READ THIS INFORMATION CAREFULLY. It is important.

PLEASE FOLLOW THESE INSTRUCTIONS TO FILE A CLAIM

ALL INFORMATION MUST BE PROVIDED IN ORDER FOR CLAIM TO BE PROCESSED. PROCESSING OF YOUR CLAIM WILL BE DELAYED IF COMPLETE INFORMATION IS NOT RECEIVED

NOTE: The accident policy benefits are limited and may not provide 100% coverage. Accident medical expense coverage under this policy is provided on an Excess Basis, and in most instances, benefits will only be paid under this plan after your own personal or group insurance has paid out its benefits. Completion of a claim form does not guarantee benefit payment. Each claim is reviewed according to the policy provisions.

Claim Guidelines: The following guidelines must be followed.

♦Answer all questions in detail (including all signatures on the front and back of the form). A claim form needs to be completed for each accident.

♦If you have other insurance, submit your claim to your other insurer. When you receive the explanation of benefits (sample attached) notice from your primary carrier, send it to us along with the corresponding HCFA/UB04 medical bills and with the fully completed claim form. You must submit the provider's medical bills; balance due statements will not be processed. Medical bills must include the procedure & diagnosis code along with the Provider's federal identification number. These bills are:

- 1) HCFA-1500 (standard form used by Providers; sample attached)
- 2) UB-04 or UB-92 (standard form used by Hospitals sample attached)
- 3) ADA Dental Claim Form and a letter from the dentist verifying the injured tooth was whole, sound and natural. (All dental bills must be submitted through your primary insurance's medical and dental plans first before submitting the bills to WebTPA)

It would be helpful if the following was given to all providers the injured person is seeking treatment from:

1. WebTPA contact information
2. Organization/School name found on the claim form
3. Policy number found on the claim form

This way the providers of service can work directly with the claim office and provide them with the correct billing forms (itemized bill to include procedure & diagnosis code and tax id number) needed to process a claim.

♦If you already paid the medical bill, include a paid receipt or a copy of your cancelled check at the same time you submit the medical bill. Otherwise payment will be made to the providers of service (Hospital, Physician or Others).

♦Send all correspondence to WebTPA, Inc., **P.O. Box 2415 Grapevine, TX 76099-2415**. The claim form must be sent within 90 days of the date you first received medical care. Any bills not filed with the claim form should be sent, within 90 days of the date you received medical care, to the Company identified with claimant's name, Organization or School name and date of Accident. File claim electronically by clicking [here](#).

♦If you change your address, please notify WebTPA, Inc. by sending notification to WebTPA so that there is no delay in processing any claims.

♦Please contact WebTPA, Inc. by calling **866-975-9468** if you would like to check the status of your claim or if you have any questions on how your claim was processed or the benefit paid.

Common Causes For Delays In Processing Claims

1. Claim Forms Not Completed In Full or Not Submitted.
2. Balance Due, Balance Forward, or Past Due Statements Submitted for Bills.
3. Explanation of Benefits from Primary Carrier Not Provided with the Bills.

KEEP COPIES OF ALL CLAIM FORMS, MEDICAL BILLS, AND CORRESPONDENCE FOR YOUR OWN RECORDS UNTIL YOUR CLAIM HAS BEEN PROCESSED.

SAMPLE HCFA 1500

PLEASE DO NOT STAPLE IN THIS AREA

HEALTH INSURANCE CLAIM FORM

1. MEDICARE MEDICAID CHAMPVA CHAMPVA GROUP HEALTH PLAN OTHER 2. INSURER'S ID NUMBER 3. PATIENT'S NAME (Last, First, Middle Initial) 4. PATIENT'S DATE OF BIRTH 5. PATIENT'S ADDRESS (City, State, ZIP) 6. PATIENT'S POLICY GROUP OR PLAN NUMBER 7. PATIENT'S DATE OF BIRTH 8. PATIENT'S POLICY GROUP OR PLAN NUMBER 9. PATIENT'S DATE OF BIRTH 10. PATIENT'S POLICY GROUP OR PLAN NUMBER 11. PATIENT'S DATE OF BIRTH 12. PATIENT'S POLICY GROUP OR PLAN NUMBER 13. PATIENT'S DATE OF BIRTH 14. PATIENT'S POLICY GROUP OR PLAN NUMBER 15. PATIENT'S DATE OF BIRTH 16. PATIENT'S POLICY GROUP OR PLAN NUMBER 17. PATIENT'S DATE OF BIRTH 18. PATIENT'S POLICY GROUP OR PLAN NUMBER 19. PATIENT'S DATE OF BIRTH 20. PATIENT'S POLICY GROUP OR PLAN NUMBER 21. PATIENT'S DATE OF BIRTH 22. PATIENT'S POLICY GROUP OR PLAN NUMBER 23. PATIENT'S DATE OF BIRTH 24. PATIENT'S POLICY GROUP OR PLAN NUMBER 25. PATIENT'S DATE OF BIRTH 26. PATIENT'S POLICY GROUP OR PLAN NUMBER 27. PATIENT'S DATE OF BIRTH 28. PATIENT'S POLICY GROUP OR PLAN NUMBER 29. PATIENT'S DATE OF BIRTH 30. PATIENT'S POLICY GROUP OR PLAN NUMBER 31. PATIENT'S DATE OF BIRTH 32. PATIENT'S POLICY GROUP OR PLAN NUMBER 33. PATIENT'S DATE OF BIRTH 34. PATIENT'S POLICY GROUP OR PLAN NUMBER 35. PATIENT'S DATE OF BIRTH 36. PATIENT'S POLICY GROUP OR PLAN NUMBER 37. PATIENT'S DATE OF BIRTH 38. PATIENT'S POLICY GROUP OR PLAN NUMBER 39. PATIENT'S DATE OF BIRTH 40. PATIENT'S POLICY GROUP OR PLAN NUMBER 41. PATIENT'S DATE OF BIRTH 42. PATIENT'S POLICY GROUP OR PLAN NUMBER 43. PATIENT'S DATE OF BIRTH 44. PATIENT'S POLICY GROUP OR PLAN NUMBER 45. PATIENT'S DATE OF BIRTH 46. PATIENT'S POLICY GROUP OR PLAN NUMBER 47. PATIENT'S DATE OF BIRTH 48. PATIENT'S POLICY GROUP OR PLAN NUMBER 49. PATIENT'S DATE OF BIRTH 50. PATIENT'S POLICY GROUP OR PLAN NUMBER 51. PATIENT'S DATE OF BIRTH 52. PATIENT'S POLICY GROUP OR PLAN NUMBER 53. PATIENT'S DATE OF BIRTH 54. PATIENT'S POLICY GROUP OR PLAN NUMBER 55. PATIENT'S DATE OF BIRTH 56. PATIENT'S POLICY GROUP OR PLAN NUMBER 57. PATIENT'S DATE OF BIRTH 58. PATIENT'S POLICY GROUP OR PLAN NUMBER 59. PATIENT'S DATE OF BIRTH 60. PATIENT'S POLICY GROUP OR PLAN NUMBER 61. PATIENT'S DATE OF BIRTH 62. PATIENT'S POLICY GROUP OR PLAN NUMBER 63. PATIENT'S DATE OF BIRTH 64. PATIENT'S POLICY GROUP OR PLAN NUMBER 65. PATIENT'S DATE OF BIRTH 66. PATIENT'S POLICY GROUP OR PLAN NUMBER 67. PATIENT'S DATE OF BIRTH 68. PATIENT'S POLICY GROUP OR PLAN NUMBER 69. PATIENT'S DATE OF BIRTH 70. PATIENT'S POLICY GROUP OR PLAN NUMBER 71. PATIENT'S DATE OF BIRTH 72. PATIENT'S POLICY GROUP OR PLAN NUMBER 73. PATIENT'S DATE OF BIRTH 74. PATIENT'S POLICY GROUP OR PLAN NUMBER 75. PATIENT'S DATE OF BIRTH 76. PATIENT'S POLICY GROUP OR PLAN NUMBER 77. PATIENT'S DATE OF BIRTH 78. PATIENT'S POLICY GROUP OR PLAN NUMBER 79. PATIENT'S DATE OF BIRTH 80. PATIENT'S POLICY GROUP OR PLAN NUMBER 81. PATIENT'S DATE OF BIRTH 82. PATIENT'S POLICY GROUP OR PLAN NUMBER 83. PATIENT'S DATE OF BIRTH 84. PATIENT'S POLICY GROUP OR PLAN NUMBER 85. PATIENT'S DATE OF BIRTH 86. PATIENT'S POLICY GROUP OR PLAN NUMBER 87. PATIENT'S DATE OF BIRTH 88. PATIENT'S POLICY GROUP OR PLAN NUMBER 89. PATIENT'S DATE OF BIRTH 90. PATIENT'S POLICY GROUP OR PLAN NUMBER 91. PATIENT'S DATE OF BIRTH 92. PATIENT'S POLICY GROUP OR PLAN NUMBER 93. PATIENT'S DATE OF BIRTH 94. PATIENT'S POLICY GROUP OR PLAN NUMBER 95. PATIENT'S DATE OF BIRTH 96. PATIENT'S POLICY GROUP OR PLAN NUMBER 97. PATIENT'S DATE OF BIRTH 98. PATIENT'S POLICY GROUP OR PLAN NUMBER 99. PATIENT'S DATE OF BIRTH 100. PATIENT'S POLICY GROUP OR PLAN NUMBER

SAMPLE UB-04

UB-04

1. PATIENT NAME 2. PATIENT ADDRESS 3. PATIENT DATE OF BIRTH 4. PATIENT POLICY GROUP OR PLAN NUMBER 5. PATIENT DATE OF BIRTH 6. PATIENT POLICY GROUP OR PLAN NUMBER 7. PATIENT DATE OF BIRTH 8. PATIENT POLICY GROUP OR PLAN NUMBER 9. PATIENT DATE OF BIRTH 10. PATIENT POLICY GROUP OR PLAN NUMBER 11. PATIENT DATE OF BIRTH 12. PATIENT POLICY GROUP OR PLAN NUMBER 13. PATIENT DATE OF BIRTH 14. PATIENT POLICY GROUP OR PLAN NUMBER 15. PATIENT DATE OF BIRTH 16. PATIENT POLICY GROUP OR PLAN NUMBER 17. PATIENT DATE OF BIRTH 18. PATIENT POLICY GROUP OR PLAN NUMBER 19. PATIENT DATE OF BIRTH 20. PATIENT POLICY GROUP OR PLAN NUMBER 21. PATIENT DATE OF BIRTH 22. PATIENT POLICY GROUP OR PLAN NUMBER 23. PATIENT DATE OF BIRTH 24. PATIENT POLICY GROUP OR PLAN NUMBER 25. PATIENT DATE OF BIRTH 26. PATIENT POLICY GROUP OR PLAN NUMBER 27. PATIENT DATE OF BIRTH 28. PATIENT POLICY GROUP OR PLAN NUMBER 29. PATIENT DATE OF BIRTH 30. PATIENT POLICY GROUP OR PLAN NUMBER 31. PATIENT DATE OF BIRTH 32. PATIENT POLICY GROUP OR PLAN NUMBER 33. PATIENT DATE OF BIRTH 34. PATIENT POLICY GROUP OR PLAN NUMBER 35. PATIENT DATE OF BIRTH 36. PATIENT POLICY GROUP OR PLAN NUMBER 37. PATIENT DATE OF BIRTH 38. PATIENT POLICY GROUP OR PLAN NUMBER 39. PATIENT DATE OF BIRTH 40. PATIENT POLICY GROUP OR PLAN NUMBER 41. PATIENT DATE OF BIRTH 42. PATIENT POLICY GROUP OR PLAN NUMBER 43. PATIENT DATE OF BIRTH 44. PATIENT POLICY GROUP OR PLAN NUMBER 45. PATIENT DATE OF BIRTH 46. PATIENT POLICY GROUP OR PLAN NUMBER 47. PATIENT DATE OF BIRTH 48. PATIENT POLICY GROUP OR PLAN NUMBER 49. PATIENT DATE OF BIRTH 50. PATIENT POLICY GROUP OR PLAN NUMBER 51. PATIENT DATE OF BIRTH 52. PATIENT POLICY GROUP OR PLAN NUMBER 53. PATIENT DATE OF BIRTH 54. PATIENT POLICY GROUP OR PLAN NUMBER 55. PATIENT DATE OF BIRTH 56. PATIENT POLICY GROUP OR PLAN NUMBER 57. PATIENT DATE OF BIRTH 58. PATIENT POLICY GROUP OR PLAN NUMBER 59. PATIENT DATE OF BIRTH 60. PATIENT POLICY GROUP OR PLAN NUMBER 61. PATIENT DATE OF BIRTH 62. PATIENT POLICY GROUP OR PLAN NUMBER 63. PATIENT DATE OF BIRTH 64. PATIENT POLICY GROUP OR PLAN NUMBER 65. PATIENT DATE OF BIRTH 66. PATIENT POLICY GROUP OR PLAN NUMBER 67. PATIENT DATE OF BIRTH 68. PATIENT POLICY GROUP OR PLAN NUMBER 69. PATIENT DATE OF BIRTH 70. PATIENT POLICY GROUP OR PLAN NUMBER 71. PATIENT DATE OF BIRTH 72. PATIENT POLICY GROUP OR PLAN NUMBER 73. PATIENT DATE OF BIRTH 74. PATIENT POLICY GROUP OR PLAN NUMBER 75. PATIENT DATE OF BIRTH 76. PATIENT POLICY GROUP OR PLAN NUMBER 77. PATIENT DATE OF BIRTH 78. PATIENT POLICY GROUP OR PLAN NUMBER 79. PATIENT DATE OF BIRTH 80. PATIENT POLICY GROUP OR PLAN NUMBER 81. PATIENT DATE OF BIRTH 82. PATIENT POLICY GROUP OR PLAN NUMBER 83. PATIENT DATE OF BIRTH 84. PATIENT POLICY GROUP OR PLAN NUMBER 85. PATIENT DATE OF BIRTH 86. PATIENT POLICY GROUP OR PLAN NUMBER 87. PATIENT DATE OF BIRTH 88. PATIENT POLICY GROUP OR PLAN NUMBER 89. PATIENT DATE OF BIRTH 90. PATIENT POLICY GROUP OR PLAN NUMBER 91. PATIENT DATE OF BIRTH 92. PATIENT POLICY GROUP OR PLAN NUMBER 93. PATIENT DATE OF BIRTH 94. PATIENT POLICY GROUP OR PLAN NUMBER 95. PATIENT DATE OF BIRTH 96. PATIENT POLICY GROUP OR PLAN NUMBER 97. PATIENT DATE OF BIRTH 98. PATIENT POLICY GROUP OR PLAN NUMBER 99. PATIENT DATE OF BIRTH 100. PATIENT POLICY GROUP OR PLAN NUMBER

SAMPLE ADA DENTAL CLAIM FORM

American Dental Association Dental Claim Form

1. Type of Transaction (Mark all that apply) 2. Insurance Company Name, Address, City, State, ZIP Code 3. Patient Name, Address, City, State, ZIP Code 4. Date of Birth (MM/DD/YYYY) 5. Patient's Relationship to Person Named in #3 6. Date of Birth (MM/DD/YYYY) 7. Gender 8. Patient's Relationship to Person Named in #3 9. Date of Birth (MM/DD/YYYY) 10. Patient's Relationship to Person Named in #3 11. Date of Birth (MM/DD/YYYY) 12. Patient's Relationship to Person Named in #3 13. Date of Birth (MM/DD/YYYY) 14. Patient's Relationship to Person Named in #3 15. Date of Birth (MM/DD/YYYY) 16. Patient's Relationship to Person Named in #3 17. Date of Birth (MM/DD/YYYY) 18. Patient's Relationship to Person Named in #3 19. Date of Birth (MM/DD/YYYY) 20. Patient's Relationship to Person Named in #3 21. Date of Birth (MM/DD/YYYY) 22. Patient's Relationship to Person Named in #3 23. Date of Birth (MM/DD/YYYY) 24. Patient's Relationship to Person Named in #3 25. Date of Birth (MM/DD/YYYY) 26. Patient's Relationship to Person Named in #3 27. Date of Birth (MM/DD/YYYY) 28. Patient's Relationship to Person Named in #3 29. Date of Birth (MM/DD/YYYY) 30. Patient's Relationship to Person Named in #3 31. Date of Birth (MM/DD/YYYY) 32. Patient's Relationship to Person Named in #3 33. Date of Birth (MM/DD/YYYY) 34. Patient's Relationship to Person Named in #3 35. Date of Birth (MM/DD/YYYY) 36. Patient's Relationship to Person Named in #3 37. Date of Birth (MM/DD/YYYY) 38. Patient's Relationship to Person Named in #3 39. Date of Birth (MM/DD/YYYY) 40. Patient's Relationship to Person Named in #3 41. Date of Birth (MM/DD/YYYY) 42. Patient's Relationship to Person Named in #3 43. Date of Birth (MM/DD/YYYY) 44. Patient's Relationship to Person Named in #3 45. Date of Birth (MM/DD/YYYY) 46. Patient's Relationship to Person Named in #3 47. Date of Birth (MM/DD/YYYY) 48. Patient's Relationship to Person Named in #3 49. Date of Birth (MM/DD/YYYY) 50. Patient's Relationship to Person Named in #3 51. Date of Birth (MM/DD/YYYY) 52. Patient's Relationship to Person Named in #3 53. Date of Birth (MM/DD/YYYY) 54. Patient's Relationship to Person Named in #3 55. Date of Birth (MM/DD/YYYY) 56. Patient's Relationship to Person Named in #3 57. Date of Birth (MM/DD/YYYY) 58. Patient's Relationship to Person Named in #3 59. Date of Birth (MM/DD/YYYY) 60. Patient's Relationship to Person Named in #3 61. Date of Birth (MM/DD/YYYY) 62. Patient's Relationship to Person Named in #3 63. Date of Birth (MM/DD/YYYY) 64. Patient's Relationship to Person Named in #3 65. Date of Birth (MM/DD/YYYY) 66. Patient's Relationship to Person Named in #3 67. Date of Birth (MM/DD/YYYY) 68. Patient's Relationship to Person Named in #3 69. Date of Birth (MM/DD/YYYY) 70. Patient's Relationship to Person Named in #3 71. Date of Birth (MM/DD/YYYY) 72. Patient's Relationship to Person Named in #3 73. Date of Birth (MM/DD/YYYY) 74. Patient's Relationship to Person Named in #3 75. Date of Birth (MM/DD/YYYY) 76. Patient's Relationship to Person Named in #3 77. Date of Birth (MM/DD/YYYY) 78. Patient's Relationship to Person Named in #3 79. Date of Birth (MM/DD/YYYY) 80. Patient's Relationship to Person Named in #3 81. Date of Birth (MM/DD/YYYY) 82. Patient's Relationship to Person Named in #3 83. Date of Birth (MM/DD/YYYY) 84. Patient's Relationship to Person Named in #3 85. Date of Birth (MM/DD/YYYY) 86. Patient's Relationship to Person Named in #3 87. Date of Birth (MM/DD/YYYY) 88. Patient's Relationship to Person Named in #3 89. Date of Birth (MM/DD/YYYY) 90. Patient's Relationship to Person Named in #3 91. Date of Birth (MM/DD/YYYY) 92. Patient's Relationship to Person Named in #3 93. Date of Birth (MM/DD/YYYY) 94. Patient's Relationship to Person Named in #3 95. Date of Birth (MM/DD/YYYY) 96. Patient's Relationship to Person Named in #3 97. Date of Birth (MM/DD/YYYY) 98. Patient's Relationship to Person Named in #3 99. Date of Birth (MM/DD/YYYY) 100. Patient's Relationship to Person Named in #3

SAMPLE EOB (EXPLANATION OF BENEFITS)

UNITEDHEALTHCARE SERVICE LLC
GREENSBORO SERVICE CENTER
P O BOX 740800
ATLANTA, GA 30374-0800
PHONE: 1-800-838-8010
VISIT WWW.MYUHC.COM FOR SELF SERVICE

UnitedHealthcare
A UnitedHealth Group Company

PAGE: 1 OF 1
DATE: 04/29/18
SSN/ID #:
EMPLOYEE:
CONTRACT:
BENEFIT PLAN: PFIZER INC

EXPLANATION OF BENEFITS

1. PATIENT/RELAT. CLAIM NUMBER 2. PROVIDER/SERVICE 3. DATE OF SERVICE 4. AMOUNT CHARGED 5. NOT COVERED 6. AMOUNT ALLOWED 7. CO-PAY/DEDUCTIBLE 8. PLAN COVERS 9. BENEFIT AVAILABLE 10. REMARK CODE

1061512101 MEDICAL SERVICES 03/19/10 379.00 297.83 81.17 81.17 80% 64.94* 4C

TOTAL 379.00 297.83 81.17 81.17

MEDICARE PAID 44.64
PLAN PAYS 20.30

(*) INDICATES PAYMENT ASSIGNED TO PROVIDER

REMARK CODE(S) LISTED BELOW ARE REFERENCED IN THE "SERVICE DETAIL" SECTION UNDER THE HEADING "REMARK CODE"
(4C) THIS PLAN DETERMINES BENEFITS ONCE MEDICARE MAKES PAYMENT. IF MEDICARE PAYS LESS THAN THIS PLAN'S BENEFIT, THIS PLAN WILL CONSIDER THE DIFFERENCE. THIS PLAN'S ALLOWABLE BENEFITS ARE BASED ON THE MEDICARE APPROVED AMOUNT IF THE PHYSICIAN OR PROVIDER ACCEPTED MEDICARE'S ASSIGNMENT OR ON THE LIMITING CHARGE IF THEY DID NOT ACCEPT THE ASSIGNMENT. THE PATIENT IS RESPONSIBLE FOR THE DIFFERENCE BETWEEN THE ALLOWABLE AMOUNT AND THE TOTAL AMOUNT PAID BY BOTH PLANS. THE PATIENT MUST PAY ANY APPLICABLE PLAN DEDUCTIBLES AND CO-PAYS BEFORE THIS PLAN CAN PAY ANY BENEFITS.

BENEFIT PLAN PAYMENT SUMMARY INFORMATION

SATISFIED 2019 TO DATE DEDUCTIBLE OUT OF POCKET

FAMILY \$5 \$1000.00 \$1328.77
\$500.00 \$1281.45

PLAN YEAR 2018 FAMILY \$1000.00 \$4000.00
INDV \$500.00 \$4000.00



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 & EOB'S 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
File Electronically: Click [Here](#)

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 RETURNED ▶

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 sponsored 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

Mother/Guardian Name _____
Employer Name and Address _____ Phone No. () _____
_____ ☐ Self Employed ☐ Unemployed

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

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 _____

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

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: _____

FRAUD NOTICE STATEMENTS

NOTICE TO APPLICANTS: "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 MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES."

RESIDENTS OF 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 OF FINES OR CONFINEMENT IN PRISON, OR ANY COMBINATION THEREOF."

RESIDENTS OF ALASKA APPLICANTS: "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."

RESIDENTS OF ARKANSAS APPLICANTS: "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."

RESIDENTS OF ARIZONA APPLICANTS: "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."

RESIDENTS OF CALIFORNIA: "FOR YOUR PROTECTION CALIFORNIA LAW REQUIRES THE FOLLOWING TO APPEAR ON THIS FORM: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT INFORMATION TO OBTAIN OR AMEND INSURANCE COVERAGE OR TO MAKE A CLAIM FOR THE PAYMENT OF A LOSS IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN STATE PRISON."

RESIDENTS OF COLORADO APPLICANTS: "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 FROM INSURANCE PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATORY AGENCIES."

RESIDENTS OF DELAWARE: "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."

RESIDENTS OF DISTRICT OF COLUMBIA APPLICANTS: "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."

RESIDENTS OF FLORIDA APPLICANTS: "ANY PERSON WHO, KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE."

RESIDENTS OF IDAHO: "ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO DEFRAUD OR DECIEVE ANY INSURANCE COMPANY, FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY."

RESIDENTS OF INDIANA: "ANY 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."

RESIDENTS OF KANSAS APPLICANTS: "ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON CAUSES TO BE PRESENTED OR PREPARES WITH KNOWLEDGE OR BELIEF THAT IT WILL BE PRESENTED TO OR BY AN INSURER, PURPORTED INSURER, BROKER OR ANY AGENT THEREOF, ANY WRITTEN STATEMENT AS PART OF, OR IN SUPPORT OF, AN APPLICATION FOR THE ISSUANCE OF, OR THE RATING OF AN INSURANCE POLICY, OR A CLAIM FOR PAYMENT OR OTHER BENEFIT PURSUANT TO AN INSURANCE POLICY WHICH SUCH PERSON KNOWS TO CONTAIN MATERIALLY FALSE INFORMATION CONCERNING ANY FACT MATERIAL THERETO, OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT WHICH IS A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES."

RESIDENTS OF KENTUCKY APPLICANTS: "ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILED 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."

RESIDENTS OF LOUISIANA APPLICANTS: "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."

RESIDENTS OF MAINE APPLICANTS: "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 A DENIAL OF INSURANCE BENEFITS."

RESIDENTS OF MARYLAND APPLICANTS: "ANY PERSON WHO KNOWINGLY AND WILLFULLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF 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."

RESIDENTS OF MINNESOTA APPLICANTS: "ANY PERSON WHO SUBMITS AN APPLICATION OR FILES A CLAIM WITH INTENT TO DEFRAUD OR HELPS COMMIT A FRAUD AGAINST AN INSURER IS GUILTY OF A CRIME."

RESIDENTS OF NEW HAMPSHIRE: "ANY PERSON WHO, WITH THE 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."

RESIDENTS OF NEW JERSEY APPLICANTS: "ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE OR MISLEADING INFORMATION IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES."

RESIDENTS OF NEW MEXICO APPLICANTS: "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."

RESIDENTS OF NEW YORK APPLICANTS: "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 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."

RESIDENTS OF OHIO APPLICANTS: "ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST ANY INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD."

RESIDENTS OF OKLAHOMA APPLICANTS: "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."

RESIDENTS OF OREGON APPLICANTS: "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, MAY BE VIOLATING STATE LAW."

RESIDENTS OF PENNSYLVANIA APPLICANTS: "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."

RESIDENTS OF RHODE ISLAND: "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 OR MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON."

RESIDENTS OF TENNESSEE APPLICANTS: "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."

RESIDENTS OF TEXAS APPLICANTS: "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."

RESIDENTS OF VERMONT APPLICANTS: "ANY PERSON WHO KNOWINGLY PRESENTS A FALSE STATEMENT IN AN APPLICATION FOR INSURANCE MAY BE GUILTY OF A CRIMINAL OFFENSE AND SUBJECT TO PENALTIES UNDER STATE LAW."

RESIDENTS OF VIRGINIA APPLICANTS: "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 AND DENIAL OF INSURANCE BENEFITS."

RESIDENTS OF WASHINGTON APPLICANTS: "IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSES OF DEFRAUDING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES, AND DENIAL OF INSURANCE BENEFITS."

RESIDENTS OF WEST VIRGINIA APPLICANTS: "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."