Gallagher Affinity Insurance Services, Inc. DBA First Agency

Claim Serial Number (for office use only)

ACCIDENT CLAIM FORM
PARENT/GUARDIAN TO COMPLETE ALL INFORMATION MUST BE COMPLETE OR CLAIM CANNOT BE PROCESSED

Insurance coverage is underwritten by Berkley Life and Health Insurance Company, (domiciled in Iowa - California Certificate of Authority #08527) or StarNet Insurance Company (domiciled in Iowa - California Certificate of Authority #6978).

Student's Full Name: _____ Exact Date of Accident: _____

Last Five Digits of Student's Social Security Number: _____ Student's Date of Birth: _____

Please note the last five digits of the Injured Person's Social Security Number MUST be provide as required by the Center for Medicare Services pursuant to Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007.

Father	Mother
Father's Full Name:	Mother's Full Name:
Home Address:	Home Address:
City: State: Zip:	City: State: Zip:
Home Phone:	Home Phone:
Employer Name:	Employer Name:
Employer Address:	Employer Address:
City: State: Zip:	City: State: Zip:
Self-Employed: ☐Yes ☐No	Self-Employed: ☐Yes ☐No
PLEASE COMPLETE THE FOLLOWING SECTION EVEN IF NO BENEFITS ARE PROVIDED:	PLEASE COMPLETE THE FOLLOWING SECTION EVEN IF NO BENEFITS ARE PROVIDED:
Do you have insurance? ☐Yes ☐No Is this student covered? ☐Yes ☐No	Do you have insurance? ☐Yes ☐No Is this student covered? ☐Yes ☐No
Name of Insurance Plan:	Name of Insurance Plan:
Phone Number: Group No.:	Phone Number: Group No.:
If you are employed, but your dependent is not covered under your employer's plan, a letter to this effect from your employer is required.	If you are employed, but your dependent is not covered under your employer's plan, a letter to this effect from your employer is required.

AUTHORIZATION – To Permit use and Disclosure of Health Information

This Authorization was prepared by First Agency for purposes of obtaining information necessary to process a claim for benefits.

I hereby authorize any physician or medical practitioner, hospital, other organization, institution, or person that has any medical records or knowledge of me or my family as to diagnosis, treatment, and prognosis regarding any physical, mental, drug or alcohol condition of any kind, and all such information is to be given to Berkley Life and Health Insurance Company, StarNet Insurance Company (Berkley), or its authorized Administrators or their legal representatives.

Any information obtained will not be released by the Company, except to persons or organizations performing business or legal services in connection with my claim. A photocopy of this authorization shall be valid as the original and is valid for 24 months from the date shown below (In AZ, CA, CT, GA, HI, IL, ME, MA, MN, NV, NC, NJ, NM, OH, and VA authorization shall be valid during

the duration of the claim. In WI, authorization is valid during the duration of the claim or 24 months, whichever is longer). I understand that my authorized representative or I will receive a copy of this authorization upon request. I also authorize Berkley or its authorized Administrators to release medical and billing information to any family member or health care provider if necessary to facilitate any potential payments.

I understand that I have the right to revoke this Authorization, in writing, at any time by sending written notification to my agent or to First Agency at the above address. I understand that a revocation will not be effective to the extent we have relied on the use or disclosure of the protected health information or if my Authorization was obtained as a condition to determine my eligibility for benefits. Revocation requests must be sent in writing to the attention of the Claims Supervisor.

I understand that First Agency may condition payment of a claim upon my signing this authorization, if the disclosure of information is necessary to determine the level or validity of the claim payment. I also understand, once information is disclosed to us pursuant to this Authorization, the information will remain protected by First Agency in accordance with federal or state law.

I understand that I or my authorized representative is entitled to receive a copy of this authorization upon request.

This Authorization is valid from the date signed for the duration of the claim.

Important Notice: 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**. For residents of New York:** 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. (Fraud language varies by state, for additional state specific fraud warning language, please see below)

_____	_____
Name of Claimant	Name of Authorized Representative or Next of Kin
_____	_____
Signature of Claimant (if claimant is 18 or older)	Signature of Authorized Representative or Next of Kin
_____	_____
Date	Relationship of Authorized Representative or Next of Kin to Claimant
	_____
	Date

*__Attention California Residents__ - please refer to following link for an important notice regarding the collection of Personal Information. https://www.berkley.com/privacy#californiaCollectionAtNotice

SCHOOL/ADMINISTRATOR/POLICYHOLDER TO COMPLETE

School Student Attends: _____ in _____ School District

Student's Full Name (Last, First, MI): _____ Sex: ☐ Male ☐ Female Grade: _____

Student's Home Address: _____

Date of Accident: _____ Time of Accident: _____ ☐ AM ☐ PM

Detailed Description of Accident: How did it occur? (or attach an accident report completed by the school representative who witnessed the accident) _____

_____

_____

_____

Where did it occur? _____

Par of body injured: _____ ☐ Right ☐ Left

Activity: _____ ☐ Interscholastic ☐ Intramural ☐ Club ☐ Other (describe)_____

Name of school authority supervising activity: _____

Was supervisor a witness to the accident? ☐ Yes ☐ No If No, date reported to school: _____

_____ _____ _____

Signature of School Official Title of School Official Date

IMPORTANT NOTICE

For residents of Alaska: 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.

For residents of Arizona: 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.

For residents of California: For your protection California law requires the following to appear on this form: Any person who knowingly presents 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.

For residents of Colorado: 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.

For residents of Delaware and Idaho: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information is guilty of a felony.

For residents of Florida: 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.

For residents of Indiana: A 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.

For residents of Kansas: 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 may be guilty of insurance fraud as determined by a court of law and may be subject to fines and confinement in prison.

For residents of Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files 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.

For residents of Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For residents of Maine, Tennessee, Virginia and Washington: 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.

For residents of Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

For residents of New Hampshire: Any person who, with a 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.

For residents of New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

For residents of New Mexico: 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.

For residents of Ohio and Oklahoma: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

For residents of Oregon: 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 may be guilty of a crime and may be subject to fines and confinement in prison.

For residents of Pennsylvania: 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.

For residents of Vermont: Any person who knowingly presents a false statement in a claim for proceeds of an insurance policy may be guilty of a criminal offense and subject to penalties under state law.