STUDENT INSURANCE
A VENBROOK COMPANY

Voluntary Student Accident Medical Insurance

K-12 Schools 2025-26

Accidents aren't supposed to happen, but they do.

School recess, after-school care, intercollegiate sports, field trips, and general school-related activities can all lead to unexpected injuries. Your school offers Voluntary Accident Insurance Plans, providing affordable protection during school hours or around the clock to ensure your loved ones get the care they need without financial hardship to your family. Choose from coverage options ranging from Low to High and find the plan that best fits your family's needs and budget.

Any enrolled student is eligible for coverage.

- School Time Accident Only
- Optional Football Coverage
- 24-Hour Accident Only
- 24-Hour Dental

Voluntary Accident plans offered by your school are considered excess plans.

Enrolling is easy and only takes a few minutes.

Go online at https://bit.ly/3Q5hrzi

1. Click on "Enroll Online".
2. Select your state and click "Look Up".
3. Select your school or district from the list.
4. Review the available plan options and make your selections.
5. Complete the online application.
6. Pay a one-time, annual cost via credit or debit card.
7. Print the confirmation of purchase as your proof of coverage.

Filing a Claim:

Complete the Gerber Life claim form with details of the injury and any additional insurance*

- Access a claim form at k12specialmarkets.com/claimforms.
- Select your state and click “Look Up” to select your school or district.
- Forms requires a parent and a school official’s signature. Be sure to include any information about private or additional insurance coverage, if applicable.
- Submit your completed form by mail, fax or electronically.
- An acknowledgment letter will be sent to the address on file, accompanied with a claim number.
- Reference your claim number when submitting any bills for treatment or medical care received from a provider.

** If you have private insurance, this voluntary accident plan will be secondary to your existing insurance. If you are covered by state-funded insurance (such as Medi-Cal/Medicaid, Medicare, or military insurance), or if you are uninsured, this plan will act as primary coverage and help cover eligible expenses.*

About Student Insurance:

Since 1950, Student Insurance (SI) has delivered competitive pricing on comprehensive Student Accident Insurance coverage to the K-12 segment. SI is dedicated to helping families manage the unexpected costs of student injuries through flexible, easy-to-access coverage options. Comprehensive policy details regarding benefits, exclusions, and limitations are available by contacting your school or district office.

Please note: Students are able to purchase coverage only if their school district is a policyholder with the insurance company.

How can we help?
Contact a Student Healthcare Expert at: SIRep@studentinsuranceusa.com to learn more.

Student Insurance
6320 Canoga Ave, 12th Floor
Woodland Hills, CA 91367
Studentinsuranceusa.com

Youth Insurance Agency, Inc. DBA Student Insurance | CA License 0386216
6320 Canoga Ave, 12th Floor • Woodland Hills, CA 91367 • www.studentinsuranceusa.com

2025 – 2026 STUDENT ACCIDENT INSURANCE COVERAGE

OPTIONAL SCHOOL TIME ACCIDENT COVERAGE - Insurance coverage is provided for covered Injuries incurred during the hours and days when school is in session and while attending or participating in school sponsored and supervised activities on or off school premises. Includes participation in: Interscholastic Sports, excluding high school interscholastic tackle football (see below Optional Football Coverage option); Summer Recreation Activities sponsored by the school; One-Day School Field Trips (no Overnight) and School Sponsored Religious Activities. Coverage is provided for traveling to, during or after such activities as a member of a group in transportation furnished or arranged by the Policyholder and traveling directly to or from their home premises and the school or the site of a covered activity.
Annual Premium: Plan "Low" – $14.00 Plan "Medium" – $28.00 Plan "High" – $43.00

OPTIONAL 24-HOUR ACCIDENT COVERAGE - Insurance coverage is provided around the clock, 24 Hours per day. Provides coverage during the weekends and vacation periods including the entire summer. Students are protected while at Home or away, any place, any time, anywhere. Coverage is provided for participation in Interscholastic Sports, excluding high school interscholastic tackle football (see below Optional Football Coverage option).
Annual Premium: Plan "Low" – $82.00 Plan "Medium" – $105.00 Plan "High" – $210.00

OPTIONAL FOOTBALL COVERAGE - Covers Accidents occurring while participating in high school interscholastic tackle football practice or competition. Travel is covered when going directly and uninterruptedly to or from such practice or competition as part of a group in transportation furnished or arranged by the Policyholder. Refer to benefits and limitations described inside this brochure. Optional Football Coverage begins on the date of premium receipt and ends on the last day of practice or competition. Ninth Graders who play with 9th graders ONLY are not charged extra for football coverage. Their Optional School-Time or Optional 24-Hour Accident Coverage will apply if purchased.
Annual Premium: Plan "Low" – $85.00 Plan "Medium" – $115.00 Plan "High" – $215.00

OPTIONAL 24-HOUR DENTAL COVERAGE (Can be purchased separately or with other coverage) – Insurance coverage is in effect 24 Hours a day. Injury must be treated within 60 days after the Accident occurs. Benefits are payable within 12 months after the date of Injury. The maximum eligible expenses payable per covered Injury is $25,000. In addition, when the dentist certifies that treatment must be deferred until after the Benefit Period, deferred benefits will be paid to a maximum of $1,000. The Student must be treated by a legally qualified dentist who is not a member of the student's Immediate Family for Injury to teeth. Coverage is limited to treatment of sound, natural teeth. **Annual Premium: $8.00**

COVERAGE PERIOD – Coverage under the Optional School-Time Accident Coverage, the Optional 24-Hour Accident Coverage and the Optional 24-Hour Dental Coverage starts on the date of premium receipt but not before the start of the school year. Optional School-Time Accident Coverage ends at the close of the regular nine-month school term, except while the student is attending classroom sessions exclusively sponsored and solely supervised by the School during the summer. Optional 24-Hour Accident and Dental Coverage ends when school reopens for the following school year. Coverage is available under the plan throughout the school year at the premiums quoted **(no pro rata premiums available)**.

SCHEDULE OF BENEFITS

Coverage for Injuries due to Accidents only

Maximum Benefit:	**Plan "Low"**	**Plan "Medium"**	**Plan "High"**
School-Time Option	$25,000	$50,000	$100,000
24-Hour Option	$25,000	$50,000	$100,000
Football Option	$25,000	$50,000	$100,000
Injuries Involving Motor Vehicles	$10,000	$10,000	$ 10,000
Death Benefit/Double Dismemberment	$10,000	$20,000	$ 20,000
Single Dismemberment	$ 5,000	$10,000	$ 10,000
Loss Period for Medical Benefits	Treatment must begin within 60 days from the date of Injury		
Benefit Period for Medical and AD&D/Loss of Sight Benefits	1 Year	1 Year	1 Year
Excess Coverage Applicability	Full Excess	Full Excess	Full Excess
Hospital/Facility Services - Inpatient			
Hospital Room and Board (Semi-Private Room Rate)	65% RE*	75% RE*	80% RE*
Inpatient Hospital Miscellaneous	65% RE*	75% RE*	80% RE*
Hospital/Facility Services - Outpatient			
Free-Standing Ambulatory Surgical Facility	65% RE* to $500 Maximum	75% RE* to $800 Maximum	80% RE* to $1,500 Maximum
Outpatient Hospital Miscellaneous (Except physician services and x-rays paid as below)	65% RE* to $500 Maximum	75% RE* to $800 Maximum	80% RE* to $1,500 Maximum
Hospital Emergency Room	65% RE* to $500 Maximum	75% RE* to $800 Maximum	80% RE* to $1,500 Maximum
Physician's Services			
Surgical	65% RE*	75% RE*	80% RE*
Assistant Surgeon	25% of Surgical Benefits	25% of Surgical Benefits	25% of Surgical Benefits
Anesthesiologist	25% of Surgical Benefits	25% of Surgical Benefits	25% of Surgical Benefits
Physician's Outpatient Treatment in connection with Physical Therapy and/or Spinal Manipulation	65% RE* / $25 Visit/5 Visit Max.	75% RE* / $30 Visit/7 Visit Max.	80% RE* / $40 Visit/8 Visit Max.
Physician's Non-surgical Treatment (Except as above)	65% RE*	75% RE*	80% RE*
Other Services			
Registered Nurses' Services	65% RE*	75% RE*	80% RE*
Prescriptions - outpatient	65% RE*	75% RE*	80% RE*
Laboratory Tests – Outpatient	65% RE*	75% RE*	80% RE*
X-rays, includes interpretation – Outpatient	65% RE*	75% RE*	80% RE*
Diagnostic Imaging (MRI, CAT Scan, etc) includes interpretation	65% RE*	75% RE*	80% RE*
Ground Ambulance	65% RE*	75% RE*	80% RE*
Durable Medical Equipment (includes Orthopedic Braces & Appliances)	65% RE*	75% RE*	80% RE*
Dental Treatment to sound, natural teeth due to covered injury	65% RE* to $500 Maximum	75% RE* to $800 Maximum	80% RE* to $1,500 Maximum
Replacement of eyeglasses, hearing aids, contact lenses, if medical treatment is also received for the covered injury.	$150 Maximum	$500 Maximum	$700 Maximum

***RE means Reasonable Expense**

GER_0418 EFTB(0009)

2025 – 2026 ENROLLMENT APPLICATION (please print or type)

_____
Student's Last Name Student's First Name Student's Middle Initial Grade

Address _____ City _____ State _____ Zip _____

Telephone Number _____ Birthdate _____

School System _____ Name of School _____

Check your selection:

Plan "Low"	❑ School-Time $14.00	❑ 24-Hour Accident $ 82.00	❑ Football $ 85.00	❑ 24-Hour Dental $8.00
Plan "Medium"	❑ School-Time $28.00	❑ 24-Hour Accident $105.00	❑ Football $115.00	❑ 24-Hour Dental $8.00
Plan "High"	❑ School-Time $43.00	❑ 24-Hour Accident $210.00	❑ Football $215.00	❑ 24-Hour Dental $8.00

Please make check payable to Gerber Life Insurance Company

Total Enclosed: _____

Signature of Parent or Guardian _____ Date _____

EXCESS COVERAGE PROVISION The Company will pay Reasonable Expenses that are not recoverable from any Other Plan. The Company will determine the amount of benefits provided by Other Plans without reference to any coordination of benefits, non-duplication of benefits, or similar provisions. The amount from Other Plans includes any amount, to which the Insured is entitled, whether or not a claim is made for the benefits. This Blanket Student Accident Insurance is secondary to all other policies. This provision will not apply if the total Reasonable Expenses incurred for Hospital and Professional Services Benefits are less than the amount stated in the Schedule of Benefits under Excess Coverage Applicability.

MEDICAL BENEFITS When a covered Injury to a student results in 1) treatment by a legally qualified Physician or surgeon (other than a member of the immediate family or person retained by the school) or 2) Hospital confinement, and treatment begins within 60 days from the date of Injury, the Company will pay the benefit as shown in the Schedule of Benefits, subject to the Excess Coverage Provision above. Only eligible medical expenses incurred by the Insured within 52 weeks from the date of the Accident are covered. Benefits for any one Accident shall not exceed in the aggregate the maximum stated in the Medical Benefit plan purchased. Expenses incurred after one year from the date of Injury are not covered, even though the service is a continuing one, or one that is necessarily delayed beyond one year from the date of Injury.

ACCIDENTAL DEATH, DISMEMBERMENT AND LOSS OF SIGHT When a covered Injury results in any of the Losses to the Insured which are stated in the Schedule of Benefits for Accidental Death, Dismemberment, or Loss of Sight then the Company will pay the benefit stated in the schedule for that Loss. The Loss must be sustained within 365 days after the date of the Accident.

The maximum benefit payable under this provision is stated in the Schedule of Benefits under Maximums and Benefit Period: 1) Life 2) Both Hands or Both Feet or Sight of Both Eyes; 3) Loss of One Hand and One Foot; 4) Loss of One Hand and Entire Sight of One Eye; 5) Loss of One Foot and Entire Sight of One Eye; 6) Loss of One Hand or Foot; 7) Loss of Sight in One Eye; 8) Loss of Thumb and Index Finger of the Same Hand. Half of the maximum benefit will be paid for the Loss of one Hand, one Foot or the Sight of one eye. Loss of Hand or Foot means the complete Severance through or above the wrist or ankle joint. Loss of Sight means the total, permanent Loss of Sight in One Eye. The Loss of Sight must be irrecoverable by natural, surgical or artificial means. Loss of Thumb and Index Finger of the Same Hand means complete Severance through or above the metacarpophalangeal joints of the same hand (the joints between the fingers and the hand). Severance means the complete separation and dismemberment of the part from the body. If the Insured suffers more than one of the above covered losses as a result of the same Accident the total amount the Company will pay is the maximum benefit. Benefits paid under this provision will be paid in addition to any other benefits provided by the Policy. Benefits under this provision are subject to all other provisions of the Policy, including all Coverage and Limitations, Maximums and Exclusions.

DEFINITIONS Injury means bodily injury caused by an Accident. The Injury must occur while the Policy is in force and while the Insured is covered under the Policy. The Injury must be sustained as stated on the face page of the Policy, except where specifically stated otherwise in the Policy. **Accident** means a sudden, unexpected and unforeseen, identifiable event producing at the time objective symptoms of an Injury. The Accident must occur while the Insured is covered under the Policy. **Other Plan** means any other valid and collectible insurance or self-funded plan such as: individual and family type insurance coverage; group, blanket or franchise insurance, group hospital, medical service, pre-payment, trustee, Union Welfare; Blue-Cross, Blue Shield, group practice or other pre-payment coverage; labor-management plans, or employee benefit organization plans; self-funded ERISA plan, Workers' Compensation Law, Occupational Disease Law or any similar legislation; Medicare; or "No-Fault" auto legislation, where applicable. **Reasonable Expense** means the average amount charged by most providers for treatment, service or supplies in the geographic area where the treatment, service or supply is provided. Such services and supplies must be recommended and approved by a Physician.

EXCLUSIONS No Benefits are payable for Hospital and Professional Services for the following: 1) Injuries which are not caused by an Accident; 2) Treatment for hernia, regardless of cause, Osgood Schlatter's disease, or osteochondritis; 3) Injury sustained as a result of operating, riding in or upon, or alighting from a two-, three-, or four-wheeled recreational motor vehicle or snowmobile; 4) Aggravation, during a Regularly Scheduled Activity, of an Injury the Insured suffered before participating in that Regularly Scheduled Activity, unless the Company receives a written medical release from the Insured's Physician; 5) Injury sustained as a result of practice or play in interscholastic tackle football and/or sports, unless the premium required under the Football and/or Sports Coverage provision has been paid; 6) Any expense for which benefits are payable under a Catastrophic Accident Insurance Program of the State Interscholastic Activities Association; 7) Treatment performed by a member of the Insured's Immediate Family or by a person retained by the School; 8) Injury caused by war or acts of war; suicide or intentionally self-inflicted Injury, while sane or insane; violating or attempting to violate the law; the taking part in any illegal occupation; fighting or brawling except in self defense; being legally intoxicated or under the influence of alcohol as defined by the laws of the state in which the Injury occurs; or being under the influence of any drugs or narcotic unless administered by or on the advice of a Physician; 9) Medical expenses for which the Insured is entitled to benefits under any (a) Workers' Compensation act; or (b) mandatory no-fault automobile insurance contract; or similar legislation; 10) Expense incurred for treatment of temporomandibular joint dysfunction and associated myofacial pain; and 11) Expenses incurred for experimental or investigational treatment or procedures.

RETAIN THIS DESCRIPTION FOR YOUR RECORDS

This is not a Policy, rather a brief description of the benefits provided under the master policy issued to the school. Please refer to the master policy for further details. **IMPORTANT NOTICE – THIS POLICY DOES NOT PROVIDE COVERAGE FOR SICKNESS. This brochure has been designed to illustrate the highlights of this insurance. All information in this brochure is subject to the provisions of Policy Form COL-11(CA), underwritten by Gerber Life Insurance Company (the Company). If there is any conflict between this brochure and the Policy, the Policy will prevail. Please see the Master Policy for individual state details.**

HOW TO FILE A CLAIM

Written notice of claim must be given to the Company within 90 days after the occurrence or commencement of any loss covered by this policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the Named Insured to the Company, with information sufficient to identify the Named Insured shall be deemed notice to the Company. Written proof of loss must be furnished to the Company at its said office within 90 days after the date of such loss.

In the event of an Accident, students should: 1) Secure treatment at the nearest medical facility of their choice; 2) If you have other insurance, submit your claim to your other insurer. When you receive the explanation of benefits notice from your primary carrier, send it to us; 3) Obtain a receipt (if payment of any bills were made) and itemized copy of charges from the provider of medical services and send copies of their itemized bills and the fully completed and **signed** accident claim form to the claims office – mail all correspondence to WEB-TPA, P.O. Box 2415, Grapevine, TX 76099-2415; and 3) **Call 1-866-975-9468** with any Claims questions.

UNDERWRITTEN BY:
Gerber Life Insurance Company
White Plains, NY 10605

MARKETING AGENT:
Student Insurance
6320 Canoga Ave, 12th Floor
Woodland Hills, CA 91367
(310) 826-5688

To apply for coverage, please enroll on-line with a credit card at www.k12specialmarkets.com ***or cut along the dotted line, complete the form and mail it, along with your check or money order, to the Please Return To: address shown below.***

Please Return To: Student Insurance
c/o K12Special Markets Plan Administrators
1055 Main Street, Suite 101
Stevens Point, WI 54481

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.

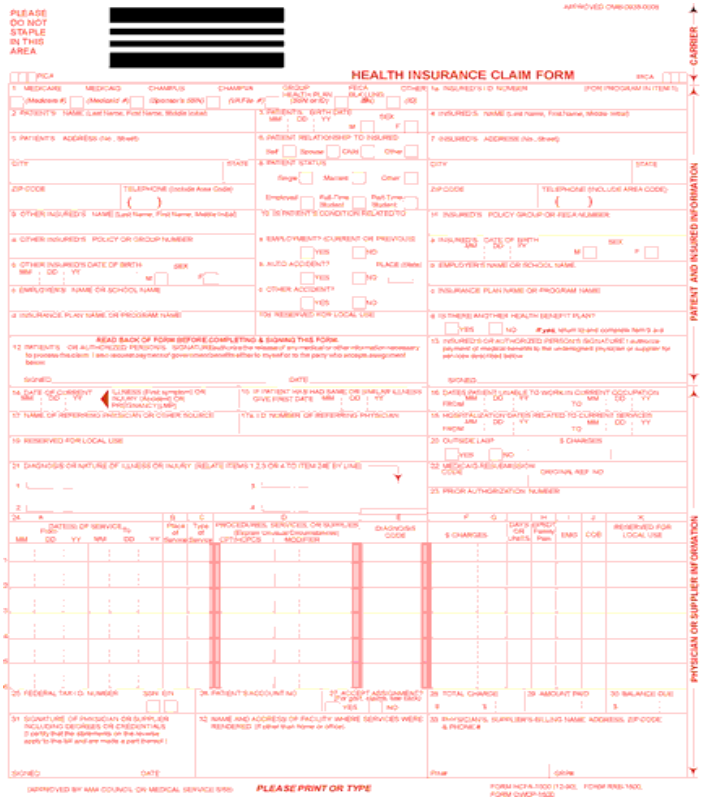
♦Please contact WebTPA, Inc. by calling **866-975-9468** if you would like to check the status of your claim or if you have any questions on how your claim was processed or the benefit paid.

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

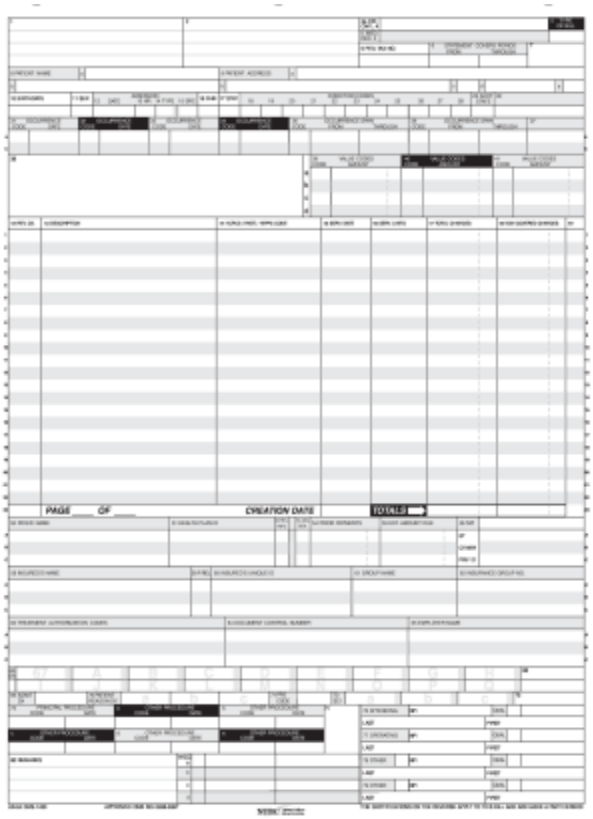


PLEASE DO NOT STAPLE IN THIS AREA

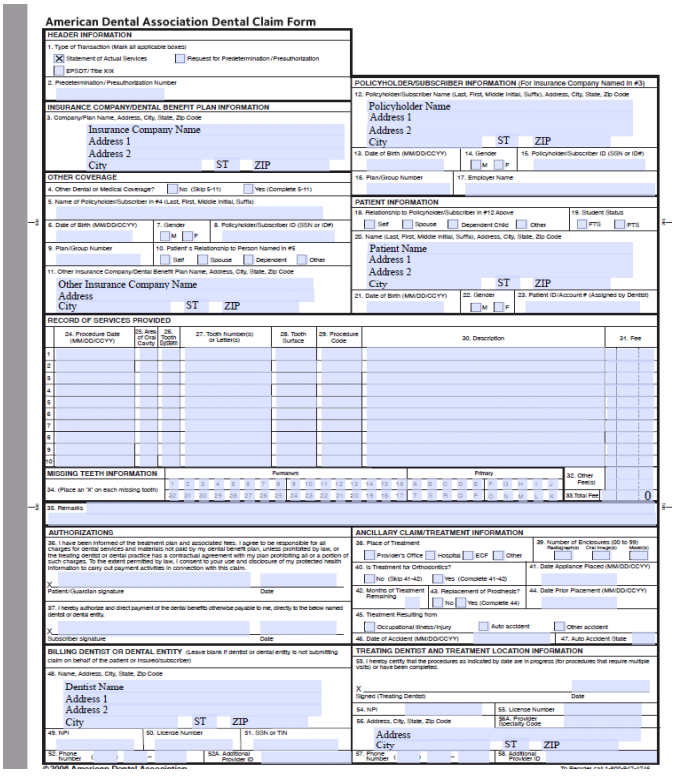
HEALTH INSURANCE CLAIM FORM

PLEASE PRINT OR TYPE

SAMPLE UB-04



SAMPLE ADA DENTAL CLAIM FORM



American Dental Association Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)
Statement of Actual Services
Request for Predetermination / Preauthorization
EPSDT/ Title XIX

2. Predetermination / Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code
Insurance Company Name
Address 1
Address 2
City ST ZIP

OTHER COVERAGE

4. Other Dental or Medical Coverage? No (Skip to 5-11) Yes (Complete 5-11)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY)

7. Gender M F

8. Policyholder/Subscriber ID (SSN or ID#)

9. Plan/Group Number

10. Patient's Relationship to Person Named in #5
Self Spouse Dependent Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code
Other Insurance Company Name
Address
City ST ZIP

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
Policyholder Name
Address 1
Address 2
City ST ZIP

13. Date of Birth (MM/DD/CCYY)

14. Gender M F

15. Policyholder/Subscriber ID (SSN or ID#)

16. Plan/Group Number

17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above
Self Spouse Dependent Child Other

19. Student Status
FTS PTS

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
Patient Name
Address 1
Address 2
City ST ZIP

21. Date of Birth (MM/DD/CCYY)

22. Gender M F

23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description	31. Fee
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							

MISSING TEETH INFORMATION

Permanent: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32

Primary: A B C D E F G H I J K L M N O P Q R S T

32. Other Fee(s)

33. Total Fee 0

34. (Place an 'X' on each missing tooth)

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X
Patient/Guardian signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X
Subscriber signature Date

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)

38. Name, Address, City, State, Zip Code
Dentist Name
Address 1
Address 2
City ST ZIP

39. NPI

40. License Number

41. SSN or TIN

42. Phone Number ( ) -

43. Additional Provider ID

ANCILLARY CLAIM/TREATMENT INFORMATION

44. Place of Treatment
Provider's Office Hospital ECF Other

45. Number of Enclosures (00 to 99)
Radiographs/Perio Chart Images Models

46. Is Treatment for Orthodontics?
No (Skip 47-52) Yes (Complete 47-52)

47. Date Appliance Placed (MM/DD/CCYY)

48. Months of Treatment Remaining

49. Replacement of Prosthesis?
No Yes (Complete 50)

50. Date Prior Placement (MM/DD/CCYY)

51. Treatment Resulting from
Occupational Illness/Injury Auto accident Other accident

52. Date of Accident (MM/DD/CCYY)

53. Auto Accident State

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

54. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X
Signed (Treating Dentist) Date

55. NPI

56. License Number

56A. Provider Specialty Code

57. Address, City, State, Zip Code
Address
City ST ZIP

58. Phone Number ( ) -

58A. Additional Provider ID

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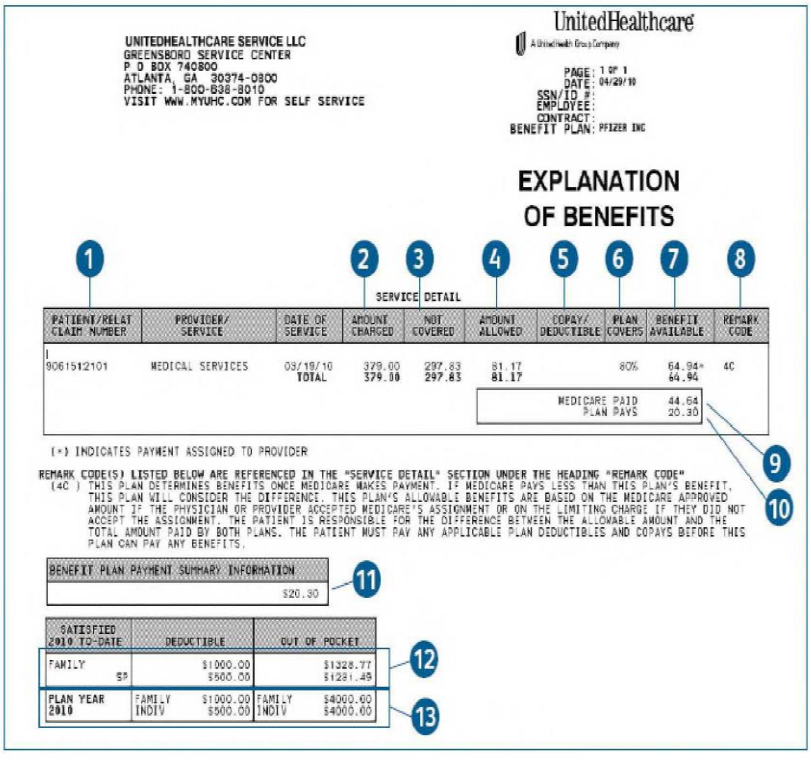
SAMPLE EOB (EXPLANATION OF BENEFITS)



UNITEDHEALTHCARE SERVICE LLC
GREENSBORO SERVICE CENTER
P O BOX 740800
ATLANTA GA 30374-0800
PHONE: 1-800-638-8010
VISIT WWW.MYUHC.COM FOR SELF SERVICE

UnitedHealthcare
A UnitedHealth Group Company

PAGE: 1 OF 1
DATE: 04/29/10
SSN/ID #:
EMPLOYEE:
CONTRACT:
BENEFIT PLAN: PFIZER INC

EXPLANATION OF BENEFITS

SERVICE DETAIL

1 PATIENT/RELAT CLAIM NUMBER	PROVIDER/ SERVICE	2 DATE OF SERVICE	3 AMOUNT CHARGED	NOT COVERED	4 AMOUNT ALLOWED	5 COPAY/ DEDUCTIBLE	6 PLAN COVERS	7 BENEFIT AVAILABLE	8 REMARK CODE
9061512101	MEDICAL SERVICES	03/19/10	379.00	297.83	81.17		80%	64.94*	4C
		TOTAL	379.00	297.83	81.17			64.94	
							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 COPAYS BEFORE THIS PLAN CAN PAY ANY BENEFITS.

BENEFIT PLAN PAYMENT SUMMARY INFORMATION	11
$20.30	

SATISFIED 2010 TO-DATE	DEDUCTIBLE	OUT OF POCKET	
FAMILY	$1000.00	$1328.77	12
SP	$500.00	$1281.45	
PLAN YEAR 2010 FAMILY	$1000.00	$4000.00	13
PLAN YEAR 2010 INDIV	$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 & 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
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 San Ysidro School District Policy Number 05-4215-25

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: _____