



Summit America Insurance Services, L.C.
 7400 College Blvd., Suite 100
 Overland Park, KS 66210

ACCIDENT CLAIM FORM

TO BE COMPLETED BY PARENT/PARTICIPANT

NAME OF PARTICIPANT (Last Name)		(First Name)	(Middle Initial)	SOCIAL SECURITY NUMBER
PARTICIPANT ADDRESS (Street)		(City)	(State)	(Zip)
PHONE NUMBER	DATE OF BIRTH		MALE <input type="checkbox"/>	FEMALE <input type="checkbox"/>
DATE OF INJURY	TIME OF INJURY	TYPE OF ACTIVITY		
PLEASE MARK: _____ PRACTICE _____ GAME _____ TRAVEL _____ OTHER _____ _____ INTRAMURAL SPORT _____ INTERSCHOLASTIC SPORT				
DESCRIBE FULLY HOW AND WHERE THE INJURY OCCURRED _____ _____ _____				
PARENT/GUARDIAN NAME (Last Name)		(First Name)	(Middle Initial)	
ADDRESS (Street)		(City)	(State)	(Zip)
Do you have any other insurance, including but not limited to group or individual health and/or accident, government plan, or automobile plan? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, please give name, address, phone number, and policy number of this plan. _____ _____				

AUTHORIZATION TO RELEASE INFORMATION

I authorize any Health Care Provider, Insurance Company, Employer, Person or Organization to release information regarding medical, dental, mental, alcohol or drug abuse history, treatment or benefits payable, including disability or employment related information, to Summit America Insurance Services, L.C., the Plan Administrator, or their employees and authorized agents for the purpose of validating and determining benefits payable. A photo copy of this authorization shall be as valid as the original.

Signature _____ Date _____

AUTHORIZATION TO PAY PROVIDER

I authorize payment of charges associated with this incident directly to the physicians or providers. I further certify that the foregoing information is true and correct.

Signature _____ Date _____

TO BE COMPLETED BY ADMINISTRATOR

NAME OF GROUP POLICYHOLDER
ADDRESS OF POLICYHOLDER
TELEPHONE NUMBER OF POLICYHOLDER
I certify that the foregoing information is true and correct.
Authorized Signature _____ Date _____
Title _____

CLAIM FILING INSTRUCTIONS

1. Complete claim form in full.
2. Attach current itemized physician, hospital, or other providers' bills standard insurance billing form: HCFA 1500 from physician or UB 92 from hospital). These forms must show the following:
 - Patients Name
 - Condition/Diagnosis
 - Type of treatment
 - Date expense incurred
 - Charges
 - If your organization uses an incident reporting form, please attach a copy.
3. Your coverage is an excess policy unless there is no other insurance in place. Attach the primary carrier's Explanation of Benefits (EOB) showing payment or denial of each bill. "Primary Carrier" would include any and all other coverage that a participant may have.
4. To expedite proper processing, submit claim form completed in full along with the above documents to the following address:

Doug Sutton Insurance Services
Post Office Box 20104
Raleigh, North Carolina 27619
Phone: 919-836-9993 or 1-800-788-7771
Fax: 919-836-9994

Important Claim Notice

California Residents: 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.

District of Columbia & Pennsylvania Residents: 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.

Florida Residents: 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.

Kentucky Residents: 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.

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

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

New York Residents: 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.

Ohio Residents: 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.

Texas Residents: 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.

For All States Other Than Those Above: 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. This notice does not apply in Virginia.