

Plan Administered by:



COMMERCIAL TRAVELERS
MUTUAL INSURANCE COMPANY

COMMERCIAL TRAVELERS
MUTUAL INSURANCE COMPANY
COMMERCIAL TRAVELERS BUILDING
UTICA, NEW YORK 13502

For Toll-free Policyholder Service 1-800-756-3702 • Utica area 315-797-5200

Please check the correct Underwriting Company:

- COMMERCIAL TRAVELERS MUTUAL INSURANCE COMPANY
- NIAGARA LIFE AND HEALTH

Notice: When we are the secondary plan, we do not pay until after the primary plan has paid its benefits if any. We will review Usual & Customary charges of each plan and allow the highest. Any amount paid by your primary plan for an eligible expense under our plan may satisfy all or a portion of our deductible.

Instructions

- School Official completes Part A.
- Parent/Guardian completes Part B. The Claim Form must be fully completed. Forms not fully completed may cause the Claim Representative to return the Claim Form resulting in processing delays.
- Please submit the completed Claim Form within 90 days from the date of accident.
- Submitting the appropriate documentation is essential for timely adjudication of your claim expenses. Note: If you are receiving treatment from a provider (primary care physician), please request a CMS 1500. If you are receiving treatment from a hospital, please request a UB04.
- Please submit any Notice of Payment or Rejection (explanation of benefits—EOB) forms from your health insurance carrier. Any itemized billing statements submitted must include a diagnosis code and procedure code.
- Please notify all physicians, hospitals and any other healthcare providers that have or will be treating your child and provide them with these instructions. Please ask the providers to forward bills to the claims administrator at:
Commercial Travelers Mutual Insurance Company
Attn: K-12 Claim Administration • 70 Genesee Street, Utica NY 13502
Fax No. 315-797-0195

Accident Claim Form

Please print or type

Part A: School Report

Instructions — school official completes this Part A, then gives the form to the student's parent or guardian to complete Part B on the reverse side. Parent must provide name of school/school district, if not school related accident.

If you have submitted an accident report to another insurance company, please attach a copy.

Name of School <u>Duanesburg CSD</u>			School District/Policyholder <u>DCS</u> <u>SAME</u> <u>133 School Dr</u> <u>Delanson NY</u> <u>1205</u>		
Phone No.			Address		
Street/Box#		City	State	Zip	Policy No. <u>2016 FA A22</u>
Name of Student				<input type="checkbox"/> Male <input type="checkbox"/> Female	Grade
Date of Accident		How Accident Occurred			
Time of Accident		<input type="checkbox"/> Enroute to/from school <input type="checkbox"/> During school session <input type="checkbox"/> Practice or play of interscholastic sports Name of Sport _____ <input type="checkbox"/> JV <input type="checkbox"/> Varsity <input type="checkbox"/> Other _____			
<input type="checkbox"/> AM <input type="checkbox"/> PM					

How did accident happen?

Details of Injury — including part of body injured Left Right: _____

Name of Teacher or Coach Supervising the Activity _____

Any person who knowingly and with intent to defraud any insurance company or other person files an application for health insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, any 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 \$5,000.00 and the stated value of the claim for each such violation.

Signature of School Official/Title	Date Signed
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—Reverse side must be completed by parent or guardian—

Accident Claim Form

Please print or type

Part B: Statement of Parent or Guardian

Name of Injured Student	Social Security No.	Date of Birth / /	Date of Accident / /
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Name of Person Making this Report	Relationship to Student
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Address Street/Box# City State Zip	Telephone Home () _____ Work () _____
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Name of Student's Male Parent or Guardian	Occupation	Social Security No.
Address if different from student		

Employer's Name and Address

Name	Street/Box#	City	State	Zip	Phone #
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Name of Student's Female Parent or Guardian	Occupation	Social Security No.
Address if different from student		

Employer's Name and Address

Name	Street/Box#	City	State	Zip	Phone #
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Does either parent or guardian have Accident/Health Insurance which covers this student? Yes No
If yes, which person(s) _____

Name of Insurance Company(ies)	Name of Policyholder(s)
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or Around-the-Clock Coverage only:

Date of injury (or) onset of sickness _____ When was physician first consulted? _____

Nature of injury (or) illness _____

If injury, how and where did accident occur? _____

Have you suffered same or similar condition in the past? Yes No If "Yes," and if you were treated for, it, please give name and address of the physician who treated you _____

Dates treated _____

Give name, address and telephone number of usual family physician _____
Phone _____

I hereby authorize any physician, hospital, company, employer, or organization to release any information regarding the medical history, treatment, or benefits payable for this claim, to the Insurance Company checked on the reverse or its authorized benefit plan administrator. A photostatic copy of this authorization shall be as valid as the original.

I also authorize the Insurance Company checked on the reverse or their representatives to pay all bills in connection with this claim directly to the doctor, hospital or any other persons rendering service, and such payment shall release the Insurance Company from liability as to amounts so paid.

I hereby certify that I have read the answers to all parts of this form and to the best of my knowledge and belief the information is complete and correct as given herein.

Name of Student _____

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Signature of Parent or Guardian	Date Signed
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