PROOF OF CLAIM

There is a timely filing period of one year and ninety days. Do not wait to send information as this may result in claim denial.

Mail, Fax or Email completed form to:
STUDENT ASSURANCE SERVICES, INC.
P.O. BOX 196
STILLWATER, MINNESOTA 55082-0196

NOTICE: Anyone who knowingly misrepresents or falsifies essential information requested by this form may upon conviction be subject to fine or imprisonment.

CLAIM PROCEDURE:

1. A college official must complete and sign PART A.
2. The student must complete PART B. The student's parent or guardian should complete PART C if applicable.
3. See reverse side for important claim procedures.

PART A - NOTICE OF INJURY - (To be completed by a college official)

1. Name of College ______________________________

   College Address ______________________________
   (Street) (City) (State) (Zip)

2. Name of Student ______________________________
3. Date of injury __________ (mm/dd/yyyy) ☐ AM ☐ PM
4. Under whose supervision? ____________________ Was He/She a witness? __________
5. Where did the accident happen? ______________________________
6. During what activity/sport did the accident happen? ______________________________
7. How did the accident happen? Give complete details ______________________________

   ____

8. Part of body injured ______________________________ ☐ LEFT ☐ RIGHT

   Reported By: ______________________________
   (Signature of College Official) (Title) Date (mm/dd/yyyy)

PART B - (To be completed by the Insured Student)

1. Student's Name ______________________________ Phone __________

   Address ______________________________
   (Street) (City) (State) (Zip)

   Email Address ______________________________

   Student Social Security ☐☐☐ ☐☐ ☐☐☐☐ Student ID __________ Date of Birth __________
   Date (mm/dd/yyyy)

2. Are you employed? If so, name of employer ______________________________
3. Do you have insurance coverage? ☐ Yes ☐ No

   Name of Insurance Company ______________________________

   ☐Group ☐Individual ☐Medicaid ☐ None

PART C - (To be completed by the Student's Parent or Guardian if applicable)

1. Parent's/Guardian's Name ______________________________ Home Phone __________

   Address ______________________________
   (Street) (City) (State) (Zip)

2. Father's Occupation ______________________________ Employer __________

   Mother's Occupation ______________________________ Employer __________

3. Do you have insurance coverage? ☐ Yes ☐ No Is the student covered under your insurance plan? ☐ Yes ☐ No

   Name of Insurance Company ______________________________

   ☐Group ☐Individual ☐Medicaid ☐None

I hereby authorize any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance company, or other organization, institution, or person that has any records or knowledge of the claimant's physical or mental health, to give the information to STUDENT ASSURANCE SERVICES, INC. To facilitate rapid submission of such information, I authorize all said sources, to give such records or knowledge to any agency employed by the insurance company to collect and transmit such information. A photocopy of this authorization shall be as valid as the original. This authorization expires one year from the date signed. By entering my name below, I am indicating my intent to sign this claim form and warrant that all of the information provided is true, complete, and accurate.

__________ Date (mm/dd/yyyy)

______________________________ (Print Name of Student/Patient)

______________________________ (Student Signature or Parent/Guardian Signature, if Student is under 18 years)

STEPS TO FOLLOW WHEN FILING A CLAIM:

1. Only one Student Assurance Services, Inc. (SAS) completed claim form for each accident needs to be submitted. Students must be treated by a licensed physician or facility within the required time as stated in the policy.

2. The claim form and benefit summary are available at SAS website: www.sas-mn.com. However, using this form is not a guarantee of benefits or confirmation of coverage under the plan. Benefits and eligibility will be evaluated when the claim is submitted, subject to all applicable terms, conditions, limitations and exclusions of the plan.

3. A college official **must** complete Part A of the claim form for all college related accidents. The student must complete Part B of the claim form. The student's parent or guardian should complete Part C of the claim form if applicable. Answer all questions on the claim form.

4. Submit copies of the **itemized bills** with the completed claim form. **Balance due statements cannot be processed.** These itemized bills often called UB-04 or CMS-1500 provide the Address, Date of Service, Procedure Code, Diagnosis Code, Federal Tax ID Number and NPI number of the treating physician or facility. **This plan has a timely filing deadline, do not wait to send information.**

   Note: A copy of the claim form can be given to the treating physician or facility. The provider may submit itemized bills directly to SAS on the student's behalf. However, do NOT depend on the provider to submit the claim form or itemized bills to SAS. It is the student's responsibility to provide this information.

5. **Submit copies of itemized bills to the student's primary family and/or group insurance company first**, even if the other insurance plan has a large deductible or copay. This plan pays second or is supplemental to all other valid coverage (does not apply to SAS primary plans). This plan does not cover penalties imposed for failure to use providers preferred or designated by the other primary insurance plan. The other insurance plan will send an Explanation of Benefits (EOB) showing payment, write-off, deductible, copay, and coinsurance.

6. Mail, fax, or email the completed claim form, itemized bills and other insurance EOBs to:

STUDENT ASSURANCE SERVICES, INC.
P.O. BOX 196
STILLWATER, MN 55082-0196
Fax: (651) 439-0200
Email: claims@sas-mn.com

NO CLAIM CAN BE PROCESSED UNTIL ALL OF THE FOLLOWING DOCUMENTS HAVE BEEN PROVIDED TO SAS:

1. **Completed Claim Form**
2. **Itemized Bills (UB-04 or CMS-1500)**
3. **Explanation of Benefits (EOB) from the primary insurance plan**
4. **FOR DENTAL CLAIMS - American Dental Association Standardized itemized billing form**

PLEASE REFER TO THE MASTER POLICY ISSUED TO THE COLLEGE FOR SPECIFIC DETAILS.