PROOF OF CLAIM

There is a timely filing period. See item #4 on the reverse side of this form for State specific requirements. 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. An employee of the Policyholder must complete and sign PART A.
- 2. The Insured or the parent/guardian must complete PART B. The insured's parent/guardian should complete PART C if applicable.
- 3. See reverse side for important claim procedures.

	ART A - NOTICE OF INJURY - To be completed by the Policyholder				
•					
	Policyholder Address(Street)	(City)	(State)	(Zip)	
2.					
3.	Date of injury				
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 Rig	ht	
	Reported By:(Signature of Policyholder Official)				
PΔ	(Signature of Policyholder Official) ART B - To be completed by the Insured or the Parent/Guardian (if t			ate (mm/dd/yyyy)	
1.					
		- I none			
	Address(Street)	(City)	(State)	(Zip)	
	Email Address		•		
	Soc. Sec. # of Insured Date of Bir	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 ☐CHIP				
PA	f ART~C - To be completed by the Insured's Parent/Guardian if application	able			
1.	Parent's/Guardian's Name	Home F	Phone		
	Address(Street)	(City)	(State)	(Zip)	
2.	Father's Occupation	, ,,	, ,		
	Mother's Occupation				
3.	Do you have insurance coverage? ☐ Yes ☐ No Is the insured or				
	•	•	aranoo pian: I	1 103 LINO	
	Name of Insurance Company				
lha	•	andinal armadically rala	tod facility incu	rance company	
or of the sai info	nereby authorize any physician, medical practitioner, hospital, clinic, other medical organization, institution, or person that has any records or knowledge information to STUDENT ASSURANCE SERVICES, INC. To facilitate aid sources, to give such records or knowledge to any agency employed by formation. A photocopy of this authorization shall be as valid as the origing and. By entering my name below, I am indicating my intent to sign the	dge of the claimant's phe dge of the claimant's phe per apid submission of s by the insurance compa nal. This authorization his claim form and war	iysical or menta iuch informatio any to collect an expires one ye trant that all of	al health, to given, I authorize and transmit such ar from the date ar from the date the information	

Date (mm/dd/yyyy)

provided is true, complete, and accurate.

(Print Name of Insured/Patient)

(Insured Signature or Parent/Guardian Signature, if Insured is under age 18)

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. The insured must be treated by a licensed physician or facility within the required time as stated in the policy.
- 2. 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. The policyholder official **must** complete Part A of the claim form for all covered activity-related accidents. The insured or the parent/guardian (if the insured is a minor under age 18) must complete Part B of the claim form. The insured's parent/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.

"PROOF OF CLAIM" for all state except (NC) must be completed and submitted to the Company within one year and 90 days. (NC) within one year and 180 days.

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 insured's behalf. However, do NOT depend on the provider to submit the claim form or itemized bills to SAS. It is the insured/parent/guardian's responsibility to provide this information.

- 5. Submit copies of itemized bills to the insured'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 POLICYHOLDER FOR SPECIFIC DETAILS.

CLM-4SR (22) Page 2