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.

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

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 school official must complete and sign PART A*.
2. The student's parent or guardian must complete PART B.
3. See Page 2 for important claim procedures.

TO BE COMPLETED BY A SCHOOL OFFICIAL

PART A: NOTICE OF INJURY

1. Name of School _____ School District Name _____

   School Address _____
   (City) (State) (Zip)

2. Name of Student _____ Grade _____

3. Date of Injury _____ ○ AM ○ PM

4. Under whose supervision? _____ Was he/she a witness? _____

5. The accident was incurred while the Insured was participating in:

INTERSCHOLASTIC SPORTS

- ☐ Practice
- ☐ Game
- ☐ Travel to/from Sport

What Sport? _____

NON-INTERSCHOLASTIC SPORTS

- ☐ Travel to/from School
- ☐ In classroom
- ☐ Other - Activity _____
- ☐ On school grounds
- ☐ Non-school activity
- ☐ Physical Education

6. Part of the body injured _____ ☐ Left ☐ Right

7. Describe in detail how and where the injury occurred _____

_____

_____

_____

Reported by _____
(Signature of School Official) (Title) Date(mm/dd/yyyy)

(*Part A may be completed by the parent if Full-Time Coverage was purchased.)
IMPORTANT INFORMATION ON Page 2

TO BE COMPLETED BY A PARENT OR GUARDIAN

PART B: PARENT STATEMENT

1. Students Name _____ Date of Birth _____
   Date (mm/dd/yyyy)

   Students Social Security # _____ - _____ - _____

   Parents Name _____ Relationship to Insured _____

   Mailing Address _____
   (Street, Route, or Box) (City) (State) (Zip)

2. Home phone number _____

3. Father's Occupation _____ Employer _____

   Mother's Occupation _____ Employer _____

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

   Name of Insurance Company _____

   ☐ Group ☐ Individual ☐ Medicaid ☐ CHIP ☐ 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) (Signature of Parent or Guardian)

TO PARENT OR GUARDIAN:

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 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 school official **must** complete Part A of the claim form for all school related accidents. The parent or guardian must complete Part B – Parent Statement of the claim form. Answer all questions on the claim form. If the accident is not school related, the parent or guardian **may** complete both Part A and Part B.

4. Submit copies of the student's **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 parent/guardian's responsibility to provide this information.

5. **Submit copies of the 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 provide an Explanation of Benefits (EOB) showing payment, write-off, deductible, copay, and coinsurance.

6. Mail, fax, or email the completed claim form, student's 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 SCHOOL/SCHOOL DISTRICT FOR SPECIFIC DETAILS.