ABCover Accident

Student Accident Insurance Claim Form

School Statement

Please complete all areas below in full. If you have any questions, do not hesitate to contact Davies Life & Health at:

(844) 304-3550 | DLHSTMMclaims@us.davies-group.com

Full Legal Name of Claimant _____ Claimant is ☐ Student ☐ Staff ☐ Volunteer ☐ Other _____

Full Address of Claimant _____ Age _____ Date of Birth _____ Grade _____

Is other health coverage for the claimant on file with the school? ☐ Yes ☐ No

If ***Yes*** above, Name of Plan _____ Subscriber Name _____ Policy #_____

Name of School District _____ Name of School Site _____

Address of School _____ School Phone Number _____

Staff Member Supervising at Time of Injury (Name and Title) _____ Did They Witness the Injury? ☐ Yes ☐ No

Injury Occurred During: Interscholastic ☐ Game or ☐ Practice ☐ P.E. ☐ Field Trip ☐ Classroom ☐ Travel ☐ Other _____

Date of Injury _____ Time of Injury _____ ☐ AM ☐ PM Date Injury Was Reported to the School _____ Sport _____

Injured Body Part Area _____ ☐ Right ☐ Left Has This Condition Happened Before? ☐ Yes ☐ No If Yes, When? _____

Please Describe How and Where the Injury Happened

What Immediate Action Was Taken by Staff? ☐ First aid ☐ Called EMS ☐ Escorted to Office ☐ Other _____

Form Completed by (Name and Title) _____ Email _____

Phone Number _____ Signature _____ Date Signed _____

Thank you for your attention to this process. The next section is intended for the parent or guardian of the injured student (or for the student, if they are not a minor). Once the above section is completed, please forward this entire document to them and retain a copy for your records. Whenever possible, we recommend using email, as it creates a documented trail of communication.

Parent, Guardian, or Student — if Not a Minor

We understand how stressful and disorienting a student injury can be. If you have questions or need support at any point, please contact Davies Life & Health for assistance. They may be reached at **(844) 304-3550** or **DLHSTMMclaims@us.davies-group.com**

We also recommend scanning the QR code on the right to instantly save their contact information to your phone, so it is always accessible if needed.

Full Legal Name of Claimant _____ Phone Number _____ Email _____

Name of Claimant's Primary Physician _____ Physician's Phone Number _____

Physician's Address _____ Is Claimant a Medicare Beneficiary? ☐ Yes ☐ No

Any Other Claimant Coverage in Place? ☐ Yes ☐ No If Yes, Name of Plan(s) _____ Policy Number(s) _____

Subscriber Name _____ Subscriber Date of Birth _____

Claimant Employment Status: ☐ Full-Time ☐ Part-Time ☐ Self-Employed ☐ Unemployed Employer's Name _____

Employer's Address _____ Phone Number _____ Email _____

If the claimant is under age 26 and covered by a parent or guardian's health plan, please complete the Parent/Guardian Information section below. If the claimant is age 26 or older, you may skip this section and proceed to the Signature areas below and Authorization.

Name Parent or Guardian #1 _____ Email Address _____

Address _____ Phone Number _____

Employment Status: ☐ Full-Time ☐ Part-Time ☐ Self-Employed ☐ Unemployed If Applicable, Employer's Name _____

Employer's Address _____ Phone Number _____ Email _____

Name Parent or Guardian #2 _____ Email Address _____

Address _____ Phone Number _____

Employment Status: ☐ Full-Time ☐ Part-Time ☐ Self-Employed ☐ Unemployed If Applicable, Employer's Name _____

Employer's Address _____ Phone Number _____ Email _____

Benefit Payment Authorization
I give permission for payment to be made directly to the provider(s) of medical care or services connected to this claim.

Notice Regarding Insurance Fraud
Providing false, incomplete, or misleading information when filing an insurance claim may be considered insurance fraud—a criminal offense that can result in legal prosecution and civil penalties. I have read and acknowledge this notice, including any additional state-specific language on the reverse side.

Name _____ Relationship to Claimant _____ Signature _____ Date _____

What else Is needed to process this claim?

- If your school has not already completed the previous page, please ask them to do so.
- **IMPORTANT:** If there is any primary health coverage in place (other than Medicaid), be sure to file a claim with that plan first and send us any available Explanation of Benefits (EOBs).
- We will need specific documents related to treatment and, in most cases, your provider can send these directly to us. To help with that, we highly recommend providing their billing office with the separate ***"Information For Providers"*** document you should have received. If they are unable to send the required documents directly, you are welcome to request them yourself and we will walk you through exactly what to ask for.
- Be sure to follow any billing instructions or payment deadlines from your provider. If you are ever asked to pay for charges this plan covers, we can reimburse you directly.

Please mail, fax, or email both pages of this completed document, along with all other correspondence to:

Davies Life & Health, Inc., A Third Party Administrator for:
Certain Underwriters at Lloyd's, London
1500 Main Street, Suite 1400, Springfield, MA 01115-5189

Phone: (844) 304-3550 | Fax: (413) 747-1545 | DLHSTMMclaims@us.davies-group.com

Davies Life & Health, Inc., A Third Party Administrator for:
Certain Underwriters at Lloyd's, London
1500 Main Street, Suite 1400
PO Box 15189
Springfield, MA 01115-5189

Phone
(413) 747-0990
(800) 883-0596

Fax
(413) 747-1545

Name of Insured:	Social Security Number: (if applicable) xxx-xx-
Name of Authorized Representative if Insured is a minor:	

HIPAA (Health Insurance Portability and Accountability Act) Compliant Authorization To Obtain Information

I authorize any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance company, employer, school, the Social Security Administration, consumer reporting agency, pharmacy benefit manager, or any other person or organization having any information, whether fact or opinion, regarding illness, injury, medical history, diagnosis, treatment, prescription history, and prognosis with respect to the past, present or future physical or mental condition and treatment, including drug and alcohol abuse treatment, of the insured and any other non-medical information of the insured to give Certain Underwriters at Lloyd's, London, or its authorized representative ("Certain Underwriters at Lloyd's, London") any and all such information required by them to determine my eligibility for policy claim benefits.

I authorize Certain Underwriters at Lloyd's, London to request dates of past and present claims and names of insurers, but not medical or personal information, from the Health Claims Index operated for subscriber insurers by MIB, Inc. ("MIB"), and association of life insurance companies. I understand such information may be reported to MIB. MIB, upon request, may disclose such information about me in its file to: another member company with whom I apply for life or health insurance, or to whom I submit a claim for benefits; a governmental agency; a party to a legal or arbitration proceeding as required by law, or for other purposes as required or permitted by applicable law.

Use and Disclosure

Information obtained by use of the Authorization will be used by Certain Underwriters at Lloyd's, London to determine eligibility for benefits under an insurance policy. Any information obtained will not be released by Certain Underwriters at Lloyd's, London, to any person or organization except to medical professionals who I or Certain Underwriters at Lloyd's, London have asked to assess my medical condition, reinsuring companies, third party administrators, claim consultants or other persons or organizations performing business or legal services in connection with this claim or as may be otherwise lawfully required or as I may further authorize.

Information that I disclose to Certain Underwriters at Lloyd's, London for the purpose of determining my eligibility for coverage may be appropriately re-disclosed to third parties, as described above, and such third parties' subsequent disclosure of the information may not be limited by applicable state and/or federal privacy laws.

Agreement and Acknowledgment

I know that I may request to receive a copy of this Authorization.
I agree that a photocopy of this Authorization shall be as valid as the original.
I agree that this Authorization shall be valid for the duration of my current claim or twenty-four (24) months, whichever is shorter, unless I revoke this Authorization in writing by sending a letter to the claims representative assigned to my claim.
If I revoke this Authorization, I recognize that Certain Underwriters at Lloyd's, London may continue to consider any information that it has already obtained to evaluate my claim and may continue to gather additional information to the extent that this Authorization is not needed to gather such information. However, I understand that as a result of my revocation of this Authorization, Certain Underwriters at Lloyd's, London may be unable to gather sufficient proof to support my claim and therefore may not provide benefits.

Insured's Signature:_____ **Date**:_____
(Insured if over 18 years or age and had legal capacity or Insured's representative)

_____
(Relationship to claimant if authorized representative)

Auth. Form 001 (8/25)