

Accident Claim Form

Mail To: Legacy Insurance Network
 1827 Briargate Blvd.
 Colorado Springs, CO 80920
Questions? Contact 1-719-593-5814



On behalf of United States Fire Insurance Company

CAUTION: Any person who knowingly and with intent to defraud, or helps commit a fraud against, any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits or may be committing a fraudulent insurance act, which is a crime and subjects such person to criminal and/or civil penalties. **Residents of the following states, please see attached notice: AZ, CA, CO, HI, OK, PA, TX**

INSTRUCTIONS

The policy is Full Excess unless otherwise noted in the policy. Eligible covered expenses will be determined after benefits have been paid by other valid and collectible insurance. You **must** submit your claim to your other insurance company first. When you receive their Benefits Statement (EOB) send it to us along with the itemized bills.

- **Part I** – Must be completed by Policyholder
- **Part II** – Must be completed by claimant or by the parent or guardian, if the claimant is a minor.
- Send copies of itemized bills showing provider’s name, address, tax ID number, diagnosis and procedure codes.
- Attach Explanation of Benefits, additional bills with record of payment or denial from primary insurance carrier.
- All benefits will be payable to the physicians and providers, unless accompanied by paid receipts.
- If employed, but have no other insurance, forward employer(s) letter on employer(s) letterhead to that effect.

Claimants eligible for Medicaid benefits must first file for benefits under this policy before submitting expenses to Medicaid.

PART I – POLICYHOLDER REPORT

Name of Policyholder			Policy Number		
Policyholder Street Address		City	State	Zip Code	
Policyholder Contact		Telephone Number	Fax Number	Email Address	
Name of Claimant (Last Name, First Name)				Social Security Number	
Date of Birth	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Grade (if applicable)	Check One (if applicable) <input type="checkbox"/> Day School <input type="checkbox"/> Boarding School		

Nature of Injury (Describe, fully indicate what part of the body was injured – e.g. broken arm, sprained ankle)

Describe how the Accident occurred, provide all details. Attach a separate sheet if necessary. **MUST BE A BODILY INJURY DUE TO ACCIDENT.**

Did accident occur:

While claimant was policyholder supervised?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Accident:	Time of Accident:
During a policy holder sponsored activity?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Place of Accident:	
During scheduled policyholder hours?	<input type="checkbox"/> Yes <input type="checkbox"/> No	First Treatment Date:	
While traveling to or from a policy holder sponsored and supervised activity?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Off Policyholder premises, at home, during the weekend, holiday or summer vacation?	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Name and title of person supervising the activity? _____ Was he or she a witness? Yes No

List other Policyholder Insurance. Attach separate sheet if necessary. Policy Number(s)

Signature of Authorized Policyholder Representative _____ Title _____ Date _____

PART II – TO BE COMPLETED BY CLAIMANT OR PARENT/GUARDIAN, IN CLAIMANT IS A MINOR

Name of Father or Guardian		Social Security Number		Email Address	
Name of Mother or Guardian		Social Security Number		Email Address	
Street Address of Parents or Guardian		City	State	Zip Code	Telephone Number
Father or Guardian’s Insurance Company			Mother or Guardian’s Insurance Company		
Name of Father and Mother’s or Guardian’s Employer		Address		City	State
				Zip Code	

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PART II – TO BE COMPLETED BY CLAIMANT OR PARENT/GUARDIAN, IN CLAIMANT IS A MINOR (Continued)

List all other insurance policies under which claimant is insured		Policy Number(s)
Is the claimant enrolled in, a member of, or a participant of any of the following as an individual, employee or dependent? If so, please provide a copy of insurance card (front and back).		
Preferred Provider Organization (PPO) or similar prepaid health plan?		<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, name of PPO or Organization:		
Health Maintenance Organization (HMO) or similar prepaid health plan?		<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, name of HMO or Organization:		
If claimant has health care coverage as a dependent from a previous marriage as mandated in a divorce decree, please provide the following:		
Name of Policyholder	Name of Insurance Company	Policy Number

AFFIDAVIT: I verify that the statement on other insurance is accurate and complete. I understand that the intentional furnishing of incorrect information via the U.S. Mail may be fraudulent and violate federal laws as well as state laws. I agree that if it is determined at a later date that there are other insurance benefits collectible on this claim I will reimburse the Company to the extent for which the Company would not have been liable.

AUTHORIZATION TO RELEASE INFORMATION: I authorize any Health Care Provider, Doctor, Medical Professional, Medical Facility, Insurance Company, Person or Organization to release any information regarding medical, dental, mental, alcohol or drug abuse history, treatment or benefits payable, including disability or employment related information concerning the patient, to any United State Fire Insurance Company, the Plan Administrator or their employees and authorized agents for the purpose of validation and determining benefits payable. This data may be extracted for the use in audit or statistical purposes. I understand that I or my authorized representative will receive a copy of this authorization upon request. This authorization or a photostatic copy of the original shall be valid for the duration of this claim.

PAYMENT AUTHORIZATION: I authorize all current and future medical bills, for services rendered and billed as a result of this claim, to be made payable to the physicians and providers indicated on the invoices.

Signature (Parent or Guardian, if the claimant is a minor)	Date
X	

IMPORTANT CLAIM NOTICE

Notice to Arizona Claimants: For your protection Arizona Law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is subject to criminal and civil penalties.

Notice to California Claimants: For your protection California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Notice to Colorado Claimants: It is unlawful to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance Company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or aware payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Notice to Hawaii Claimants: For you protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment or both.

Notice to Oklahoma Claimants: Warning: Any person who knowingly, and with intent to injure, defraud or deceive any insurer make any claim for the proceeds of an insurance policy containing false, incomplete, or misleading information is guilty of a felony.

Notice to Pennsylvania Claimants: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent act, which is a crime and subjects such person to criminal and civil penalties.

Notice to Texas Claimants: Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.