

**2019-2020 STUDENT ACCIDENT CLAIM FORM**

**Please follow the time frames listed below and submit to ISDA Claims Administrator by the required due dates.**

- 1) Claim Form must be submitted no later than 90 days after the date of injury.**
  - 2) Itemized bills must be submitted no later than 90 days after the date of treatment.**
  - 3) Explanation of Benefits (EOB) must be submitted no later than 180 days after the date of treatment.**
- #1, #2 & #3 listed above must all be submitted if you have other insurance**

**INSTRUCTIONS: PLEASE RETAIN A COPY FOR YOUR FILES**

1. The school official must complete Part A.
2. The Insured's parent/guardian must complete Part B.
3. In case of dental charges, the attending dentist **must** complete the Attending Dentist's Statement on the reverse side of this form.

**PART A: NOTICE OF INJURY FROM SCHOOL (Please type or print)**

1. Name of School \_\_\_\_\_ School District Name \_\_\_\_\_  
 School Address \_\_\_\_\_ (City) \_\_\_\_\_ (State) \_\_\_\_\_ (Zip) \_\_\_\_\_
2. School Contact Name \_\_\_\_\_ School Contact Phone Number \_\_\_\_\_
3. Name of Student \_\_\_\_\_
4. Date of Injury \_\_\_\_\_ Time \_\_\_\_:\_\_\_\_AM \_\_\_\_:\_\_\_\_PM Under whose supervision? \_\_\_\_\_ Was he/she a witness? \_\_\_\_\_
5. The injury was incurred while the student was participating in: (*please check*)
 

<b>INTERSCHOLASTIC SPORTS</b> <input type="checkbox"/> Practice <input type="checkbox"/> Game <b>Name of Sport</b> _____	<b>NON-INTERSCHOLASTIC SPORTS – Where did accident occur?</b> <input type="checkbox"/> Travel to/from school <input type="checkbox"/> Non-school activity <input type="checkbox"/> In classroom <input type="checkbox"/> Other – Activity? <input type="checkbox"/> Physical Education _____ <input type="checkbox"/> On school grounds <input type="checkbox"/> Recess
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6. Part of the body injured (    ) Right (    ) Left \_\_\_\_\_
7. Describe exactly how injury happened (Please be specific) \_\_\_\_\_

Reported by \_\_\_\_\_ Signature of School Official \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_

**PART B: STATEMENT FROM PARENT OR GUARDIAN (Important Information on Reverse Side) (Please type or print)**

1. Name of Parent \_\_\_\_\_ Relationship to Student \_\_\_\_\_  
 Home Address \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_  
 \_\_\_\_\_ Home Phone Number  
 \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_  
 City State Zip Cell Phone Number
2. Father's Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Phone Number \_\_\_\_\_
3. Mother's Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Phone Number \_\_\_\_\_
4. Student's Date of Birth \_\_\_\_\_ Grade \_\_\_\_\_ M / F Student's Social Security Number \_\_\_\_\_
5. **THIS AREA MUST BE COMPLETED.** Is student covered under any other insurance plan? Yes \_\_\_\_ No \_\_\_\_ List all other insurance coverage in force  
 Name of Insurance Company \_\_\_\_\_ Group \_\_\_\_ Individual \_\_\_\_ Policy # \_\_\_\_\_  
 Phone Number (\_\_\_\_\_) \_\_\_\_\_ Whose insurance is it? (    ) Mother (    ) Father (    ) Guardian

I 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 ISDA Claims Administrator. 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 is valid from the date signed for the duration of the claim.

Date \_\_\_\_\_

Print Name of Student \_\_\_\_\_

Signature of Parent or Guardian \_\_\_\_\_

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

## ***PLEASE FOLLOW THESE INSTRUCTIONS TO FILE A CLAIM***

- Complete and submit the **Claim Form** to ISDA Claims Administrator **no later than 90 days after the date of injury**.
- **DO NOT** leave this Claim Form with the physician or hospital.
- Review the 2018-2019 Student Accident Coverage brochure for a summary of benefits, limitations, and exclusions. Please contact your child's school for a copy of the brochure, if you have not received one or download it from [www.wcsit-isda.com/sa](http://www.wcsit-isda.com/sa). An identification card is included in the brochure. Please cut out the ID card and carry it with you. It should be presented to the hospital, Doctor and Dentist along with your primary insurance ID card (if applicable) whenever you seek medical/dental attention for a school related injury.
- A school official must complete Part A for all school-related injuries. The parent or guardian must complete **all** questions in Part B – Statement from Parent or Guardian.
- Students must be treated by a licensed medical or dental provider **within 30 days** after the date of the covered injury.
- **Itemized bills** must be submitted to ISDA Claims Administrator **no later than 90 days** after the date of treatment. All bills must include the diagnosis and procedure codes.
- Please remember that this plan is **EXCESS** to all other valid coverages. If you have other insurance, you **MUST** file a claim with your primary insurance carrier first, even if you have a large deductible. You should not wait until you have all the bills and EOBs because you may miss a due date.
- When you receive the **Explanation of Benefits (EOB)** from your primary insurance carrier or claims administrator, send them to ISDA Claims Administrator **no later than 180 days** after the date of treatment.
- All documents should be sent to the following address within the **required time frames**: Student Accident Claims, ISDA Claims Administrator, 155 N. Wacker, Suite 3700, Chicago, IL 60606 or faxed to (312) 930-7232.
- For additional questions, please call (800) 419-3206 or (312) 930-6143.

### **ATTENDING DENTIST'S STATEMENT**

1. Date of Injury \_\_\_\_\_
2. If Prosthesis, is this initial placement? \_\_\_\_\_
3. Were the teeth sound or natural prior to the current treatment?    \_\_\_\_\_ YES                      \_\_\_\_\_ NO
4. Are any services covered by another plan? If so name plan?    \_\_\_\_\_ YES                      \_\_\_\_\_ NO

TOOTH NO.	DESCRIPTION OF SERVICE	DATE OF SERVICE	FEE
<b>TOTAL FEE</b>			

Print Dentist's Name

Dentist Signature

Street Address

Date

City

State

Zip

Telephone

Federal tax ID Number **(must be included)**