A Notice of Claim (Claim Form) for your Organizations Accident policy.
Please forward completed claim forms and claims questions to:

Co-Ordinated Benefit Plans
On Behalf of Aegis Security Insurance Company
P.O. Box 20874
Tampa, FL 33623

TEAM2@CBPINSURE.COM
Phone: (877) 395-9691
Fax: (800)561-8084

Important Notice – Fraud Statement
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

How to File a Medical Claim

Step 1: Submit a fully completed Notice of Claim (Claim Form) within 90 days from the Date of Accident. Only one form per accident needs to be submitted.

A. **Part I** must be completed by a Board Member of the organization (not the Parent, Claimant or Agent);
B. After reading the Fraud Statement above, the Board Member must sign and date **Part I** of the form;
C. **Part II** must be completed in full by Parent/Guardian or Adult Claimant. Do not omit any information from the Other Insurance Statement and do not answer any question "N/A";
D. After reading the Fraud Statement above, the Parent/Guardian or Adult Claimant must sign and date **Part III** the form;
E. Once the form is completed, keep a copy for your records and mail or fax the completed form to the address shown above.

Step 2:

A. Advise all doctors/hospitals/medical service providers of this coverage so they may file their claims, to include their HCFA 1500 or UB-04 or UB-92 along with copies of any Primary Insurance Explanations of Benefits ("EOB"). This coverage is Full Excess, so, if you have Primary Insurance, it must be filed before claims are submitted under this policy.
B. If you have already been to the doctor/hospital and did not know about this coverage, send itemized bills with copies of your Primary Insurance EOB's to the address above. **Itemized bills must include the Medical Provider's name, address, Tax ID Number, telephone number, the name of patient, date(s) of service, diagnosis, and description of treatment including CPT codes and amounts of charges.** Payment will be made to the Provider of Service unless a Paid Receipt is submitted with the claim.

Common Causes for Delays in Processing Claims

- **Claim Form is not Fully Completed or is not Submitted;**
- **Balance Due, Balance Forward or Past Due Statement submitted instead of Itemized Bills; and**
- **Explanation of Benefits from Primary Insurance not submitted.**

KEEP COPIES OF ALL CORRESPONDENCE UNTIL CLAIMS HAVE BEEN PROCESSED.

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PART I – PARTICIPATING ORGANIZATION STATEMENT

Policy Number ESA-Y11087	Policyholder / Organization Name	Event, Activity or Sport		
Mailing Address of Organization:		City	State	Zip Code
Claimant's Name (Injured Person)	Social Security Number	Gender ☐ M ☐ F	Date of Birth	E-Mail Address

Address of Injured Person and Best Contact Phone Number (Include Area Code)

Date and Time of Accident	Place where Accident Occurred	The injured person was a: ☐ Participant ☐ Coach ☐ Volunteer
Dental Claims	Indicate which Teeth were Involved in the Accident	Describe Condition of Injured Teeth Prior to Accident: ☐ Whole, Sound, and Natural ☐ Filled ☐ Capped ☐ Artificial

Type of Injury (Indicate Part of Body Injured – e.g. broken arm, sprained ankle, etc.)	Did Injury Result in Death? ☐YES ☐NO

Describe How Accident Occurred – Provide All Possible Details

Did Accident Occur (Check Yes or No for Each of the Following):

A. During a participating organization sponsored & supervised, or sanctioned activity? ☐YES ☐NO
B. On activity premises? ☐YES ☐NO
C. While traveling directly and uninterruptedly to or from the activity? ☐YES ☐NO
D. During a participating organization practice? ☐YES ☐NO Competition? ☐YES ☐NO

Signature of Organization Representative	Name, Title and Email address	Phone Number	Date

PART II – OTHER INSURANCE STATEMENT

Name of Person Completing Form:	Phone Number:	Email:	Relationship: ☐Injured Person ☐Parent ☐Guardian

Do you/spouse/parent have medical/health care or are you enrolled as an individual, employee or dependent member of a Health Maintenance Organization (HMO) or similar prepaid health care plan, or any other type of accident/health/sickness plan coverage through an employer, a parent's employer or other source? ☐YES ☐NO

If Yes, name of insurance company:____ **Policy #:**_______________

Mother's (Guardian's) primary employer name, address & telephone: ____

Father's (Guardian's) primary employer name, address & telephone: ____

Are you eligible to receive benefits under any governmental plan or program, including Medicare?

☐YES ☐NO If yes, please explain: ____

IF OTHER INSURANCE OR HEALTH CARE PLANS EXIST, PLEASE SUBMIT COPIES of their EXPLANATION OF BENEFITS along with your claim.

PART III – AUTHORIZATIONS

I authorize medical payments to physician or supplier for services described on any attached statements enclosed. If not signed, please provide proof of payment.

SIGNATURE____**DATE** ________________

I authorize any physician, medical professional, hospital, covered entity as defined under HIPAA, insurer or other organization or person having any records, dates or information concerning the claimant to disclose when requested to do so, all information with respect to any injury, policy coverage, medical history, consultation, prescription or treatment, and copies of all hospital or medical records or all such records in their entirety to ***Aegis Security Insurance Company*** or its designated administrator**.** A photo static copy of this authorization shall be considered as
effective and valid as the original.

I agree that should it be determined at a later date, there is other insurance (or similar), to reimburse ***Aegis Security Insurance Company*** to the extent of any amount collectible.

I understand that any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

SIGNATURE____**DATE** ________________