

MAIL CLAIM FORM TO:  
 ACADEMIC BENEFIT TRUST  
 P.O. BOX 382048  
 BIRMINGHAM, AL 35238-2048  
 (888) 283-3515 PHONE  
 (205) 313-9744 FAX

## NOTIFICATION OF INJURY

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.

Reference Number
<b>FOR OFFICE USE</b>
Policy Number
Coverage Code

**FORM MUST BE COMPLETED IN FULL & MAILED TO OUR OFFICE WITHIN 90 DAYS FROM THE DATE OF THE ACCIDENT**

<b>PART I - ACCIDENT REPORT- TO BE COMPLETED BY SCHOOL OFFICIAL</b>					
1A. Name of School			1B. Name of School District/Diocese/Association		
2A. Name of Student (Last)		(First)	(Middle Initial)	2B. Social Security No.	2C. Grade
		2D. Birth date	2E. Sex		
3. Nature of Injury (Please describe fully indicating what part of body was injured – e.g. broken arm, sprained ankle, etc.)					
4. Describe how accident occurred. (Please provide all details.) <b>MUST BE A BODILY INJURY DUE TO AN ACCIDENT.</b>					
5A. Was the accident school-related? <input type="checkbox"/> Yes <input type="checkbox"/> No			5B. Is the accident covered under a catastrophic policy? <input type="checkbox"/> Yes <input type="checkbox"/> No		
6A. Did Accident Occur:			6B. a) Date of Accident	6C. Name of Activity	
a) while the claimant was supervised? <input type="checkbox"/> Yes <input type="checkbox"/> No			b) Time		
b) during sponsored activity? <input type="checkbox"/> Yes <input type="checkbox"/> No					
c) during programmed hours? <input type="checkbox"/> Yes <input type="checkbox"/> No					
d) on activity premises? <input type="checkbox"/> Yes <input type="checkbox"/> No			6D. Name and Title of Supervisor		
e) while traveling directly and uninterruptedly to or from home premises and school for regular school sessions or school sponsored and supervised activities? <input type="checkbox"/> Yes <input type="checkbox"/> No					
7A. _____		7B. _____		C. _____	
Signature of School Officer		Title		Date	

### PART II – TO BE COMPLETED BY PARENT/GUARDIAN OR CLAIMANT (IF ADULT)

1A. Name of Father/Guardian or Claimant (if adult) <input type="checkbox"/> None		1B. Social Security No.		1C. Address/City/State/Zip		1D. Phone Number	
2A. Name of Mother/Guardian or Spouse (if adult) <input type="checkbox"/> None		2B. Social Security No.		2C. Address/City/State/Zip		2D. Phone Number	
3A. Name of Father/Guardian's or Claimant's (if adult) Employer <input type="checkbox"/> None			3B. Address/City/State/Zip of Employer			3C. Phone Number	
4A. Name of Mother/Guardian's or Spouse's (if adult) Employer <input type="checkbox"/> None			4B. Address/City/State/Zip of Employer			4C. Phone Number	
5A. List all Insurance Company(ies) under which the claimant is insured <input type="checkbox"/> None			5B. Policy Number(s)		5C.		
_____			_____		<input type="checkbox"/> Medicaid <input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Govt.		
_____			_____		<input type="checkbox"/> Medicaid <input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Govt.		
_____			_____		<input type="checkbox"/> Medicaid <input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Govt.		
_____			_____		<input type="checkbox"/> Medicaid <input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Govt.		
<b>Affidavit:</b> I verify that the above information regarding insurance is accurate and complete. I understand that the intentional furnishing of incorrect information may be fraudulent and violate federal laws as well as state laws.							
_____						_____	
Signature of Parent/Guardian or Claimant (if adult)						Date	
<b>Authorization:</b> I hereby authorize any physician or hospital who has treated or attended to the above claimant to furnish the insurance company or its representative any information requested. A photocopy of this authorization is to be considered valid.							
_____						_____	
Signature of Insured (Parent or Guardian if claimant is under 18)						Date	

**SEE CLAIM INSTRUCTIONS**

## CLAIM INSTRUCTIONS

**Treatment must commence within 90 days from the date of the accident.**

1. In case of an accident, notify the school/organization immediately.
2. Notify ALL treatment facilities (physician's office, hospital, etc.) of this insurance coverage so that any invoices and/or Explanation of Benefits (EOB) from your primary health insurance carrier can be sent directly from the medical facility to Academic Benefit Trust.
3. **Have Part I and Part II completed on the Notification of Injury form.**

**Part I - To be completed and signed by School Official.**

**Part II – To be completed and signed by Parent/Guardian or Claimant (if adult).**

Do not leave any blank spaces or write "N/A" in any space. If either parent or guardian is uninvolved, deceased, unemployed, self-employed or disabled, please state so. If you are employed, but do not have insurance, please state "NO INSURANCE" and provide us with a statement from your employer that the claimant has no insurance. Otherwise, our office will submit an insurance questionnaire to your employer to be used as verification of no dependent coverage.

4. Attach any itemized bills to the claim form, along with any corresponding Explanation of Benefits (EOB) from your primary health insurance carrier for each itemized bill. An itemized bill includes treatment rendered, the dates of the treatment, diagnosis codes, physician's or hospital's name, address and tax ID number. Balance Due bills are not acceptable. Be sure to attach any receipts for bills paid out-of-pocket. Otherwise, benefits will be paid to the provider of service. Please Note: Both an itemized bill and EOB (if applicable) must be submitted for claims to be considered for accident medical expense benefits.
5. **Mail or Fax the Notification of Injury form**, along with any other applicable correspondence to our office within 90 days from the date of the accident. Do not leave the Notification of Injury form with the school, coach, hospital, physician, etc.

**Academic Benefit Trust  
P.O. Box 382048  
Birmingham, AL 35238-2048.**

**Fax 205-313-9744**

If you need further assistance, contact Customer Service at 1-888-283-3515

If your medical coverage is under an HMO, PPO or similar plan, you must follow their requirements for obtaining benefits. Otherwise, our benefits may be reduced, where applicable, as stated in the policy provisions. This restriction does not apply in every state.