

1. PLEASE FULLY COMPLETE THIS FORM
 2. ATTACH ITEMIZED BILLS
(UB04 or HCFA-1500 Form)
 3. MAIL TO HSR
- E-mail : claims@hsri.com



8400 Belleview Drive, Suite 150
Plano, Texas 75024
Phone: (972) 512-5600 Fax: (972) 512-5820
Toll Free (800) 328-1114

Policy Name: _____

Policy Number: _____

School Name (if applicable): _____

PART I – POLICYHOLDER’S REPORT

1. Claimant’s Name (Injured Person)		2. Social Security Number		3. Gender <input type="checkbox"/> M <input type="checkbox"/> F		4. Date of Birth		5. E-Mail		
6. Address of Injured Person and Best Contact Phone Number (Include Area Code)										
7. If Applicable, Parent’s Name, Address, and Best Contact Phone Number (Include Area Code)										
8. Date and Time of Accident			9. Place where Accident Occurred				10. The injured person was a: <input type="checkbox"/> Participant <input type="checkbox"/> Staff Member <input type="checkbox"/> Guest <input type="checkbox"/> Volunteer			
Dental Claims	11. Indicate which Teeth were Involved in the Accident			12. Describe Condition of Injured Teeth Prior to Accident: <input type="checkbox"/> Whole, Sound, and Natural <input type="checkbox"/> Filled <input type="checkbox"/> Capped <input type="checkbox"/> Artificial						
13. Type of Injury (Indicate Part of Body Injured – e.g., (broken arm, sprained ankle, etc.)							Did Injury Result in Death? <input type="checkbox"/> YES <input type="checkbox"/> NO			
14. Describe How Accident Occurred – Give All Possible Details										
15. Did Accident Occur (Check Yes or No for Each of the Following):										
A. During a policyholder programmed, sponsored & supervised, or sanctioned activity?						<input type="checkbox"/> YES <input type="checkbox"/> NO				
B. On activity premises?						<input type="checkbox"/> YES <input type="checkbox"/> NO				
C. While on the job (if applicable)?						<input type="checkbox"/> YES <input type="checkbox"/> NO				
D. While traveling directly and uninterruptedly to or from home and policyholder premises?						<input type="checkbox"/> YES <input type="checkbox"/> NO				
E. During intercollegiate/scholastic athletic practice?						<input type="checkbox"/> YES <input type="checkbox"/> NO or competition? <input type="checkbox"/> YES <input type="checkbox"/> NO				
16. Name of Event or Activity					17. Name and Title of Supervisor					
18. Name of Policyholder										
19. Signature of Policyholder Representative					20. Title of Policyholder Representative			21. Date		

PART II – OTHER INSURANCE STATEMENT

Do you/spouse/parent have medical/health care or is the Claimant 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 your employer or other source on you or does your son/daughter have health care coverage as a dependent from your previous marriage as mandated in a divorce decree? YES NO

If Yes, name of insurance company _____ Policy # _____
 Name of insurance company _____ Policy # _____
 Claimant’s primary employer name, address, and phone number _____
 Mother’s primary employer name, address, and phone number _____
 Father’s primary employer name, address, and phone number _____

IF OTHER INSURANCE OR HEALTH CARE PLANS EXIST, PLEASE SUBMIT COPIES of their EXPLANATION OF BENEFITS along with your claim.
IF NO OTHER INSURANCE or HEALTH PLAN EXISTS, PLEASE READ & SIGN BELOW.
 I agree that should it be determined at a later date there is insurance (or similar), to reimburse **HEALTH SPECIAL RISK, INC.**, or the insurance company to the extent of any amount collectible.

New York Fraud Warning Notice: Any person who knowingly and with intent to defraud any insurance company or other person files and application for insurance, or statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any material fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation

SIGNATURE OF PARTICIPANT OR PARENT _____ DATE _____

PART III – AUTHORIZATION TO PAY BENEFITS TO PROVIDER

I authorize medical payments to physician or supplier for services described on any attached statements enclosed. (if not signed, submit proof of payment)

SIGNATURE _____ DATE _____

I hereby authorize any insurance company, hospital, physician or other person who has attended or examined 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. A photo static copy of this authorization shall be considered as effective and valid as the original.

SIGNATURE _____ DATE _____

By entering your name above in Part II and Part III, you are signing this claim form electronically. You agree your electronic signature is the legal equivalent of your manual/handwritten signature on this claim form.