



Boy Scouts of America

- 1. PLEASE FULLY COMPLETE THIS FORM
- 2. ATTACH ITEMIZED BILLS WITH DOCTOR'S DIAGNOSIS
- 3. MAIL TO HEALTH SPECIAL RISK, INC.

E-Mail: boyscouts@hsri.com

PTP N 00327402

HSR

Health Special Risk, Inc.

HSR Plaza

4100 Medical Parkway
 Carrollton, TX 75007-1517
 Toll Free 866-726-8870
 Fax 972-512-5820

To be completed by BSA Leader

Council Name: Sam Houston
 Address: P.O. Box 924528
Houston, TX 77292
 Telephone Number: 713-659-8111
 ACE American Insurance Company

FOR HSR USE ONLY: Claim Company # _____ Plan # _____ Location # _____

PART 1 - BSA Leader's Statement

Check One: Tiger Cub Tiger Cub Adult Varsity Scout Cub Scout Venturer Leader Committee
 Learning for Life - Explorer Paid Seasonal Staff Volunteer Seasonal Staff Other _____

Check Policy: Council Unit Campers & Special Events National Events

Pack, Troop, Post, or Team Number <u>Troop 957</u>	1. Claimant's Name (Injured/Sick Person)	2. Social Security Number - -	3. Gender _M _F	4. Birthday _ / _ / _
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5. Claimant's Address (Street, City, State, Zip Code) and best contact telephone number (include area code)

6. If applicable, parent's name, address and best contact telephone number (include area code)	7. E-Mail
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8. What date did accident happen or sickness begin?	9. Nature of injury or sickness (indicate part of body injured - such as broken arm, sprained ankle, etc.)
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10. Describe how accident occurred - give details	Did Injury Result in Death? <input type="checkbox"/> YES <input type="checkbox"/> NO
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11. Name of event or activity	12. Name and title of adult leader
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13. Signature of policyholder representative X	14. Title	15. Date
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PART 2 - 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 second insurance company _____ Policy # _____

Coverage is Primary for First \$300.00 Only, Then Excess

This policy is excess to any other available source of medical benefits if the charges are greater than \$300.00. You must file your bills through your primary/personal insurance carrier prior to this policy responding. If the total charges are less than \$300.00, we will pay without the other insurance coordination. When your primary insurance company processes the charges, they will send you an Explanation of Benefits, or "EOB." Please submit copies of their Explanation of Benefits along with your claim.

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.

Signature of participant or parent X	Witness	Date
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NOTE: 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 or misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Authorization to pay benefits to provider

I authorize medical payments to physician or supplier for services described on any attached statements enclosed.

Signature X _____ DATE _____

Authorization for release of information

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 photostatic copy of this authorization shall be considered as effective and valid as the original.

Signature X _____ DATE _____

ATTACH ITEMIZED BILLS WITH DOCTOR'S DIAGNOSIS

