PROOF OF CLAIM

This form should be completed and submitted to the Company within 90 days from date of injury.

Mail completed form to:
STUDENT ASSURANCE SERVICES, INC.
P.O. BOX 196
STILLWATER, MINNESOTA 55082

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

CLAIM PROCEDURE:

1. A school official must complete PART A*.
2. The Insured's parents or guardian must complete PART B.
3. If dental charges — have statement completed on Page 2.
4. See Page 2 for important claim procedures.

TO BE COMPLETED BY A SCHOOL OFFICIAL

PART A: NOTICE OF INJURY

1. Name of School _____ School District Name _____
   School Address _____ (City) (State) (Zip)
2. Name of Insured _____ Grade _____
3. Date of Injury _____ ☐AM ☐PM
4. Under whose supervision? _____ Was he/she a witness? _____
5. The accident was incurred while the Insured was participating in:

INTERSCHOLASTIC SPORTS

☐ Practice
☐ Game
☐ Travel

What sport? _____

NON-INTERSCHOLASTIC SPORTS

☐ Travel to/from school
☐ In classroom
☐ Physical Education
☐ On school grounds
☐ Non-school activity
☐ Other – Activity? _____

6. Part of the body injured _____ ☐R ☐L
7. Describe in detail how and where the injury occurred _____

Reported by _____
(Signature of School Official) (Title) (Date)

(*Part A may be completed by the parent if Full-Time Coverage was purchased.)
IMPORTANT INFORMATION ON Page 2

TO BE COMPLETED BY A PARENT OR GUARDIAN

PART B: PARENT STATEMENT

1. Students Name _____ Birthdate _____
   Students Social Security # _____ - _____ - _____
   Parents Name _____ Relationship to Insured _____
   Mailing Address _____
   (Street, Route, or Box) (City) (State) (Zip)
2. Home phone number _____
3. Father's Occupation _____ Employer _____
   Mother's Occupation _____ Employer _____
4. List your family or group coverage, please.
   Name of Insurance Company _____ ☐Group ☐Individual ☐PolicyNo. _____
   Address _____
   (Street) (City) (State) (Zip)

I hereby 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 STUDENT ASSURANCE SERVICES, INC. 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 expires one year from the date signed. **For electronic filing** - By entering my name below I am indicating my intent to electronically sign this claim form and warrant that all of the information provided is true, complete, and accurate.

_____ (Date) _____ (Print Name of Student/Patient) _____ (Signature of Parent or Guardian)

TO: Parent or Guardian

STEPS TO FOLLOW WHEN FILING A CLAIM:

1. Only one claim form for each accident needs to be submitted.

2. The claim form and benefit summary are available at our website: www.sas-mn.com. However, this is not a guarantee of benefits but only an explanation that is subject to all applicable terms, conditions, limitations and exclusions of the plan.

3. A school official **must** complete Part A for all school related accidents. The parent or guardian must complete **all** questions in Part B – Parent Statement. If the accident is not school related, parent or guardian **may** complete Part A. **Print a copy of the claim form to present to the treating physician or facility so they might understand what is needed from them to process your claim. Do NOT depend on the medical provider to submit the claim form. You should submit the claim directly to claims office within 90 days from date of injury.**

4. You will need to send copies of **itemized bills**. These are the original billings you receive, not monthly statements. **These itemized bills often called UB04 or CMS 1500 provide the Address, Procedure Code, Diagnosis Code, and the Provider's Tax ID Number.**

5. You will need to submit copies of all bills to your family and/or group insurance, even if you have a large deductible. This plan is supplemental to all other valid coverage. You must file a claim with your other insurance first. This plan does not cover penalties imposed for failure to use providers preferred or designated by your primary coverage. After you have received payment or copies of "Explanation of Benefits" (EOB) from your family insurance company or insurance administrator (Blue Cross, Group Health, Prudential Insurance, etc.), **send copies of itemized bills and your other insurance E.O.B.'s to: (Does not apply to our primary plans)**

STUDENT ASSURANCE SERVICES, INC.
P.O. BOX 196
STILLWATER, MN 55082-0196

NO CLAIM CAN BE PROCESSED UNTIL ALL OF THE FOLLOWING DOCUMENTS HAVE BEEN PROVIDED BY YOU OR THE MEDICAL PROVIDER.

1. **Completed Claim Form**
2. **Itemized Bills (UB04) (CMS 1500)**
3. **Explanation of Benefits from primary insurance (EOB)**

TO FILE A CLAIM FORM ON-LINE

Please complete the form fully and follow all steps explained above. When you are satisfied that the claim form is ready to be submitted to SAS, make a copy of the completed claim form to present to the physician or facility as explained above, then either:

a. Mail the claim form with any necessary supporting information, to Student Assurance Services, Inc., P.O. Box 196, Stillwater, MN 55082. Please keep a copy of the claim form your records; OR

b. Click on "Submit Form" in the upper right hand corner of the claim form to electronically send the claim form to SAS. If you have any additional or supporting information, send it to SAS by fax 1-651-439-0200 or mail it to Student Assurance Services, Inc., P.O. Box 196, Stillwater, MN 55082.

PLEASE REFER TO THE MASTER POLICY ISSUED TO THE SCHOOL/SCHOOL DISTRICT FOR SPECIFIC DETAILS.

ATTENDING DENTIST'S STATEMENT

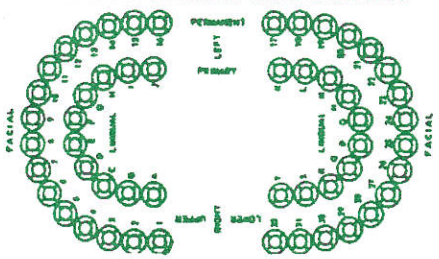
(1) DATE OF ACCIDENT

(2) IF PROTHESIS, IS THIS INITIAL PLACEMENT? ☐ YES ☐ NO

(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

IDENTIFY ALL TEETH WITH AN "X" THAT WERE INVOLVED IN THIS ACCIDENT



TOOTH NO.	DESCRIPTION OF SERVICE	DATE OF SERVICE	FEE
		TOTAL FEE	

PROVIDER'S NAME

X
SIGNATURE DEGREE

STREET ADDRESS

DATE

CITY STATE ZIP

( ) TELEPHONE

Federal ID Number — No benefits can be paid until we have your ID number.