



**MAIL CLAIM FORMS TO:** Co-ordinated Benefit Plans, PO Box 20874, Tampa, FL 33622  
**IF YOU NEED ASSISTANCE:** TOLL FREE 1-877-902-9926 / EMAIL: TEAM2@CBPINSURE.COM

**CLAIMANT'S NOTICE OF ACCIDENT**

**PART A Claim Form**

<b>1. FULL NAME (Injured Person)</b>	<b>2. DATE OF BIRTH</b>	<b>3. TELEPHONE NUMBER</b>  (       )
<b>4. STREET ADDRESS</b>	<b>5. CITY, STATE, ZIP</b>	
<b>6. POLICY HOLDER'S NAME</b>		
<b>7. POLICY NUMBER</b>	<b>8. DATE OF INJURY</b>  ____/____/____	<b>9. TIME OF INJURY</b>  _____ AM / PM
<b>10. IF HOSPITALIZED, HOSPITAL NAME</b>  HOSPITAL TEL. NO. (       )	<b>11. STREET ADDRESS</b>	
<b>12. CITY, STATE, ZIP</b>	<b>13. HOSPITAL CONFINEMENT DATES</b>  From: _____   To: _____	
<b>14. Explain HOW the accident and injury occurred. NOTE: If your organization uses an Accident Report Form, attach a copy of the Report.</b>		
<b>15. Describe the nature of injury.</b>		
<b>16. At what location did the injury occur?</b>		

**AUTHORIZED REPRESENTATIVE:** \_\_\_\_\_ (printed name)  
 \_\_\_\_\_ Telephone Number  
 \_\_\_\_\_ (       ) \_\_\_\_\_  
 \_\_\_\_\_ Date                      Signature \_\_\_\_\_

**NOTICE**

This claim form **MUST** be received by the Insurance Company within 90 days of the date of injury. Benefits will be paid for eligible expenses left unpaid by other insurance or health plans. Expenses must be incurred within 52 weeks after the date of the accident.

**CLAIM PROCEDURE**

1. Have an Official of the Organization **complete, date** and **sign** PART A.
2. The Injured Person (Insured) – or, if the Injured Person is under age 18 or is otherwise dependent, his/her Parent or Guardian – **MUST complete, date** and **sign** PART B.
3. After PARTS A and B have been completed in full, mail the form to the address shown above **within 90 days** of the date of injury.
4. Send all medical bills to your other health and accident insurance company(s) **first**, if applicable. This can include employee plans, union plans, service contracts, H.M.O. Plans, self-insured benefit plans, etc.
5. After you have received a notice of payment, notice of denial or letter stating you have met your deductible from your other insurance company(s), forward that statement, along with copies of the original bills, to the address shown above.

**PART B** – This PART MUST be completed, dated and signed by the Injured Person – or if the Injured Person is under age 18 or otherwise dependent – by his/her Parent or Guardian.

PRINT HERE – NAME OF PERSON COMPLETING FORM: \_\_\_\_\_ Check one: Injured Person  Parent  Guardian

Give the following information about the Injured Person:

1. Date of Birth Mo. Day Year / /	2. Male <input type="checkbox"/> Female <input type="checkbox"/>	3. Social Security No. / /	4. Area Code/Telephone No. ( ) _____
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5. Employer (Name) ADDRESS: (Street) (City) (State) (Zip)  
(if applicable)

Area Code/Employer Telephone No.  
( ) \_\_\_\_\_

6. Is the Injured Person covered under any other health and/or accident insurance plans? Yes  No   
If YES, give the following information:

Name of Other Insurance Company(s)	Address	Policy Number(s)
Policyholder Name and Address		Social Security No. / /
Relationship to Injured person:		Area Code/Telephone No. ( ) _____

7. If the Injured Person is married, give the following information:

Name of Spouse	Social Security No. / /
	Area Code/Telephone No. ( ) _____

I authorize any insurer, hospital, physician or other person who has attended or examined the Insured Person to disclose, when requested to do so, all information with respect to any injury, policy coverages, medical history, consultation, prescription or treatment, and copies of all hospital or medical records and itemized bills. A photostatic copy of this authorization shall be considered as effective and valid as the original. The above information is true and complete to the best of my knowledge and belief.

I also Authorize Aegis Security Insurance Company of Pennsylvania or its representatives to pay all bills in connection with this claim directly to the doctor, hospital or any other persons rendering service, and such payment shall release Aegis Security Insurance Company of Pennsylvania from liability as to amounts so paid.

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 of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime (in FL, a felony in the third degree), and in the state of New York, 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.

**X** \_\_\_\_\_  Injured Person  
Signature (in writing) of Responsible Party \_\_\_\_\_ Print Name \_\_\_\_\_ Check one:  Parent  Guardian Date: \_\_\_\_\_

**THE BENEFIT PERIOD FOR ELIGIBLE EXPENSES IS  
52 WEEKS FROM THE DATE OF ACCIDENT**