A Notice of Claim (Claim Form) for your Organization's Accident policy.
Please forward completed claim forms and claims questions to:

Co-Ordinated Benefit Plans
On Behalf of Aegis Security Insurance Company
P.O. Box 20874 Tampa, FL 33623

Email: TEAM2@CBPINSURE.COM
Phone: (877) 902-9926
Fax: (800)561-8084

Important Notice – Fraud Statement

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.

How to File a Medical Claim

Step 1: Submit a fully completed Notice of Claim (Claim Form) within 90 days from the Date of Accident. Only one form per accident needs to be submitted.

A. **Part A** must be completed by Authorized Representative of the organization (not the Parent, Claimant or Agent);
B. After reading the Fraud Statement above, Authorized Representative must sign and date **Part A** of the form;
C. **Part B** must be completed in full by Parent/Guardian or Adult Claimant. Do not omit any information from the Other Insurance Statement and do not answer any question "N/A";
D. After reading the Fraud Statement above, the Parent/Guardian or Adult Claimant must sign and date **Part B** of the form;
E. Once the form is completed, keep a copy for your records and mail, email, or fax the completed form to the address shown above.

Step 2: Advise all doctors/hospitals/medical service providers of this coverage so they may file their claims, to include their HCFA 1500 or UB-04 or UB-92 along with copies of any Primary Insurance Explanations of Benefits ("EOB"). This coverage is Full Excess, so, if you have Primary Insurance, it must be filed before claims are submitted under this policy.

If you have already been to the doctor/hospital and did not know about this coverage, send itemized bills with copies of your Primary Insurance EOB's to the address above. Itemized bills must include the Medical Provider's name, address, Tax ID Number, telephone number, the name of patient, date(s) of service, diagnosis, and description of treatment including CPT codes and amounts of charges. Payment will be made to the Provider of Service unless a Paid Receipt is submitted with the claim.

Common Causes for Delays in Processing Claims

- **Claim Form is not Fully Completed or is not Submitted;**
- **Balance Due, Balance Forward or Past Due Statement submitted instead of Itemized Bills; and**
- **Explanation of Benefits from Primary Insurance not submitted.**

KEEP COPIES OF ALL CORRESPONDENCE UNTIL CLAIMS HAVE BEEN PROCESSED.

(03/2020)

MAIL CLAIM FORMS TO: Co-ordinated Benefit Plans, PO Box 20874, Tampa, FL 33623
IF YOU NEED ASSISTANCE: TOLL FREE 1-877-902-9926
FAX 1-800-561-8084 / EMAIL: TEAM2@CBPINSURE.COM

CLAIMANT'S NOTICE OF ACCIDENT

PART A Claim Form

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

AUTHORIZED REPRESENTITIVE'S CONTACT INFORMATION AND SIGNATURE:

________________	______________________	______________________	( )________________
Date	Print Name	Signature	Telephone#

(03/2020)

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 ☐ Female ☐	3. Social Security No. / /	4. Area Code/Telephone No. ( ) ______________________

5. Employer (if applicable) (Name) ADDRESS: (Street) (City) (State) (Zip)

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_________________________________ _________________________________ Check one: ☐ Injured Person ☐ Parent ☐ Guardian Date:_________

Signature (in writing) of Responsible Party Print Name

SEE FOLLOWING PAGE FOR FRAUD WARNING NOTICES

FRAUD WARNING NOTICES:

AK: Any person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.
AL: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.
AR, DC, LA, MD, NM, RI, TX, WV: 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.
AZ: Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties."
CA: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.
CO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement or award payable for insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.
DE, ID, IN: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.
FL: Any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony of the third degree.
KY: Any person who knowingly and with intent to defraud any insurance company or other person files a 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.
ME, TN, VA, WA: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or denial of insurance benefits.
MN: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.
NH: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud as provided in section 638:20.
NJ: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.
NY: 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, 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.
OH: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.
OK: Any person who knowingly, and with any intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.
PA: 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 and subjects such person to criminal and civil penalties.
ALL OTHER STATES: 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 and subjects such person to criminal and/or civil penalties.