

# ATTENTION PARENTS AND GUARDIANS

**Supplemental Student Accident  
Insurance is Now Available**



Health Special Risk, Inc. offers two options for supplemental student accident insurance.

## At-School Coverage

At-school coverage provides protection for students enrolled full time in kindergarten through 12th grade during regular school hours for the entire school year.

## 24-Hour Coverage

This coverage provides protection 24 hours a day, seven days a week for any covered student accident that occurs anywhere, not just on school grounds.

The premium for either option is paid annually. This one-time payment provides coverage for the entire year. Both coverage options provide protection beginning from the date of enrollment in the plan.

Supplemental student accident insurance is applicable for any covered activity. Certain exclusions and limitations apply. Please read the policy information carefully for an overview of the plan.

Visit [K12StudentInsurance.com](https://www.K12StudentInsurance.com) to get started.

- 1 Check rates before purchasing
- 2 When you're ready to sign up, click **enroll now**
- 3 Purchase coverage for your student

We are here for you

For information or assistance regarding all student insurance, contact our customer service department at (866) 409-5733.



Underwritten by  
Mutual of Omaha Insurance Company

**HSR**  
Health Special Risk, Inc.

Underwritten by Mutual of Omaha Insurance Company, 3300 Mutual of Omaha Plaza, Omaha, NE 68175.

Policy Form T5MP Series 6440S NC; Series 6754S FL | Policy Form B33MP Series 8408S TX | Policy Form SR2014 TX

Riders: 868MS-EZ, 0KV5M, 6785M, 0CX5M, 867MS-EZ, 6773M, 0KV4M, 1359MS-EZ, 6653M, 850MS-EZ, 851MS-EZ, 6425M Rev 04-10, 0LJ8MS, 9130MS, 6925M, 1364MS, 0LC7M.

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# ATENCIÓN, PADRES Y GUARDIANES

Ahora está disponible el  
Seguro contra accidentes  
estudiantes adicional

Health Special Risk, Inc. ofrece dos  
opciones de seguro contra accidentes  
estudiantes adicional.

## Cobertura en la escuela

La cobertura en la escuela brinda cobertura para los  
estudiantes inscritos tiempo completo en kindergarten hasta  
el grado 12 durante el horario normal de escuela para todo el  
ciclo lectivo.

## Cobertura las 24 horas

Esta cobertura brinda protección las 24 horas al día, los siete  
días de la semana, para cualquier accidente estudiantes  
cubierto que ocurra en cualquier lugar, no solo en el territorio  
de la escuela.

La prima para cualquiera de las dos opciones se paga  
anualmente. Este pago único ofrece cobertura para todo el  
año. Ambas opciones de cobertura ofrecen protección desde la  
fecha de inscripción en el plan.

El seguro contra accidentes estudiantes adicional es aplicable  
a cualquier actividad cubierta. Se aplican ciertas exclusiones y  
limitaciones. Lea cuidadosamente la información de la póliza  
para ver una descripción general del plan.

Visita [K12StudentInsurance.com](https://www.K12StudentInsurance.com) para comenzar.

- 1 Consultar tarifas
- 2 Inscribirse ahora
- 3 Cobertura de compra

Estamos aquí para usted

Para información o asistencia sobre todos los  
seguros del estudiante, póngase en contacto con el  
departamento de servicio al cliente al (866) 409-5733.



Mutual of Omaha

Underwritten by  
Mutual of Omaha Insurance Company

**HSR**  
Health Special Risk, Inc.

Suscrito por Mutual of Omaha Insurance Company, 3300 Mutual of Omaha Plaza, Omaha, NE 68175.

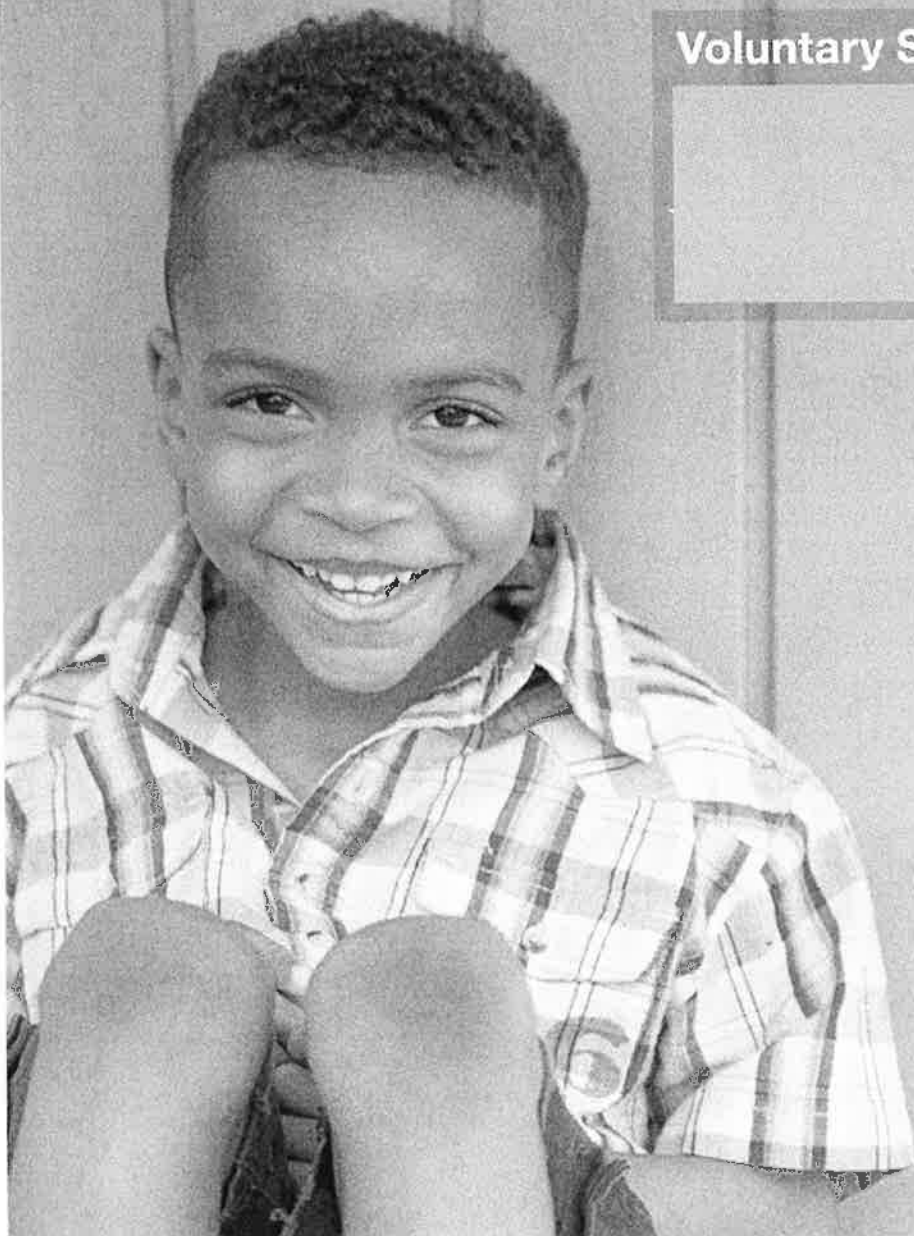
La póliza o certificado que afecta la cobertura y los servicios descritos en este aviso se proporciona exclusivamente en inglés. Así mismo, toda la documentación relacionada también se proporcionará exclusivamente en inglés. En caso de adquirir este producto, le recomendamos contactar a un traductor.

Nota: Las pólizas y certificados de aseguramiento se encuentran disponibles en español para los residentes de Puerto Rico, previa petición.

35R777 CP

# Voluntary Student Accident Insurance

## 2024-2025 NATIONAL



**Health Special Risk, Inc.**  
8400 Belleview Dr, Suite 150  
Plano, TX 75024

Phone: 866.409.5733, Ext. 5660  
Fax: 972.512.5819  
[www.healthspecialrisk.com](http://www.healthspecialrisk.com)



HSR is an independent licensed insurance agency and is authorized to sell this student accident insurance on behalf of Mutual of Omaha Insurance Company.

Coverage underwritten by: Mutual of Omaha Insurance Company, Mutual of Omaha Plaza, Omaha, NE 68175.



# NATIONAL

2024-2025

## K-12 Voluntary Student Accident Insurance Coverage

(Not Available in AR, FL, ID, KS, KY, MD, MT, NC, NH, NY, SD, TX, & WA)

Coverage underwritten by: **Mutual of Omaha Insurance Company; 3300 Mutual of Omaha Plaza; Omaha, NE 68175**

### ELIGIBILITY:

All registered students grades PreK-12 of a participating school/district.

### COVERAGE OPTIONS

**AT SCHOOL COVERAGE:** Insurance coverage is provided during the hours and days when school is in session, while attending or participating in school sponsored and supervised activities on or off school premises (i.e. day field trips) and while participating in interscholastic athletics (except injuries incurred while participating in High School Football events/activities). Coverage is provided while traveling to, during or after such activities as a member of a group in transportation furnished or arranged by the Policyholder and traveling directly to or from the Insured's home premises and school premises when school is in session. If the Policyholder provides mandatory coverage for students under an At School, Interscholastic Athletic/Activity or Football program, benefits will be payable under those programs before being considered under an At School Voluntary program.

**24-HOUR COVERAGE:** Provides coverage for injuries incurred 24-Hours a day, 365 days a year, at home, at school and while participating in interscholastic athletics (except injuries incurred while participating in High School Football events/activities). If the Policyholder provides mandatory coverage for students under an Interscholastic Athletic/Activity, Football or At School program, benefits will be payable under those programs before being considered under a 24-Hour Voluntary program.

**FOOTBALL ONLY:** Insurance coverage is provided for High School Football athletes during athletic tryouts, preseason play, practice, state interscholastic governing body approved conditioning, regular and post season play and for travel to, during or after covered athletic activities as a member of a group in transportation furnished and arranged by the school. If the Policyholder provides mandatory coverage for Football athletes under an Interscholastic Athletic/Activity or Football program, benefits will be payable under those programs before being considered under a Voluntary Football Only program.

**EXTENDED DENTAL COVERAGE:** This is supplemental coverage for expenses resulting from covered accidental dental injuries. The dental benefits provided are: (a) 100% of Allowable Expense for examinations, X-Rays, endodontics and oral surgery to a maximum of \$10,000; or (b) dental expenses toward the cost of bridges, dentures or replacement of previous dental repairs to a maximum of \$250. No coverage is provided for orthodontics (braces) for any reason or damage or loss thereof. Extended Dental Coverage must be purchased in conjunction with a 24-Hour, At School or Football program; it cannot be purchased as stand alone coverage.

**COVERAGE PERIOD** – Coverage under the At School, 24-Hour and Football programs begins on the date of premium receipt but not before the start of the school year activities. At School Coverage ends at the close of the regular nine-month school term. 24-Hour Coverage ends when school reopens for the following fall term. Coverage is available under both plans throughout the school year at the premiums quoted (**no pro rata premiums available**).

### BENEFITS

**ACCIDENT MEDICAL EXPENSE:** When a covered injury to an Insured results in treatment by a physician or surgeon beginning within 60 days of the date of the accident; we will pay benefits as shown in the **Schedule of Benefits**, in excess of the Medical Deductible, if any. Only eligible medical expenses incurred by the Insured within 52 weeks from the date of the accident are covered. Benefits for any one accident shall not exceed in the aggregate the maximum Medical Benefit of \$25,000. We will pay the Medical Expenses an Insured incurs for covered services that exceed amounts payable by any Other Insurance Plan, subject to the Deductible, Benefit Percentage, and Benefit Period.

**ACCIDENTAL DEATH AND SPECIFIC LOSS:** Benefits are paid for losses incurred within 180 days from the date of Injury. The following benefits (the largest applicable amount) are paid in addition to the medical benefit:

Loss of Life .....	\$10,000.00
Loss of both hands, both feet, sight in both eyes, speech and hearing .....	\$10,000.00
Loss of one hand, one foot, sight in one eye, speech or hearing .....	\$5,000.00
Loss of Thumb and Index Finger of the Same Hand.....	\$500.00

"Loss" means, with regard to hands and feet, actual severance above the wrist or ankle joint, with regard to sight, speech or hearing the total and irrevocable loss thereof. Loss means, with regard to thumb and index finger of the same hand, severance of two or more entire phalanges of both the thumb and index finger.

## DEFINITIONS

*Allowable Expense* means a Medical Expense otherwise payable under the policy that is not in excess of the 80<sup>th</sup> percentile identified on Context4HealthCare (the "Database"). When there is, in Our determination, minimal data available from the Database for a Medical Expense, We will determine the amount to pay by calculating the unit cost for the applicable service category using the Database and multiplying that by the relative value of the Medical Expense based upon a commercially available relative value scale selected by Us. In the event of an unusually complex medical procedure, a Medical Expense for a new procedure or a Medical Expense that otherwise does not have a relative value that is in Our determination applicable, We will assign a relative value. The Medical Expenses We pay may not reflect the actual charges of a provider and does not take into account the provider's training, experience or category of licensure. A provider may charge the Insured the difference between what the provider charges and the amount We pay under the policy. The Database will be updated by us as information becomes available from the supplier, up to twice each year. We may modify the Database in Our discretion to reflect Our experience. We have the right, in Our discretion, to substitute or replace the Database with another database or databases of comparable purpose, with or without notice.

*Injury* means bodily harm which: (1) requires treatment by a Physician; (2) results in loss due to an Accident, independent of Sickness and all other causes; and (3) occurs within the Scope of Coverage.

*Hospital* means an institution which: (1) is operated pursuant to law; (2) is primarily and continuously engaged in providing medical care and treatment to sick and injured persons on an inpatient basis; (3) is under the supervision of a staff of Physicians; (4) provides 24-hour nursing service by or under the supervision of a graduate registered nurse (R.N.); and (5) has medical, diagnostic and treatment facilities, with major surgical facilities on its premises or available to it on a prearranged basis. Hospital does not include: (1) a clinic or facility for: (a) convalescent, custodial, educational or nursing care; (b) the aged, drug addicts or alcoholics; (c) rehabilitation; or (2) a military or veterans hospital or a hospital contracted for or operated by a national government or its agency unless: (a) the services are rendered on an emergency basis; and (b) the individual has a legal liability to pay for the services given in the absence of insurance.

## EXCLUSIONS AND LIMITATIONS

We will not pay benefits for a loss due to or expenses incurred for:

(1) intentionally self-inflicted injury, suicide while sane or insane; (2) voluntary self-administration of any drug or chemical substance not prescribed by or not taken according to the directions of the Insured's Physician; (3) Injury caused by, attributable to, or resulting from the Insured's Intoxication; (4) Injury caused by, attributable to, or resulting from the Insured's use of a Controlled Substance unless administered on the advice of a Physician and taking the prescribed dosage; (5) operating a motor vehicle under the influence of a Controlled Substance unless administered on the advice of a Physician and taking the prescribed dosage; (6) operating a motor vehicle while having a blood alcohol level that equals or exceeds the legal limit for operating a motor vehicle in the state or jurisdiction where the Injury occurred; (7) commitment of or an attempt to commit a felony, or engagement in an illegal activity; (8) participation in a riot or insurrection; (9) any Injury that results from fighting, brawling, assault or battery; (10) an act of declared or undeclared war; (11) active duty service in any Armed Forces; (12) operating, learning to operate, or serving as a pilot or crew member of any aircraft unless specified in the INSURED RISKS section of this policy; (13) mountaineering (engaging in the sport of scaling mountains generally requiring the use of picks, ropes, or other special equipment); (14) parachuting, except for self-preservation; (15) snow skiing, scuba diving, bob-sledding, bungee jumping, ballooning, flight in an ultralight aircraft, sky diving, hang-gliding, glider flying, sailplaning, or parasailing; (16) participation in professional or amateur racing; (17) injuries associated with activities or travel outside the United States; (18) sickness, disease, bodily or mental infirmity or medical or surgical treatment thereof, bacterial or viral infection, regardless of how contracted. This does not exclude bacterial infection that is the natural and foreseeable result of an Injury or accidental food poisoning; (19) dental treatment or dental X-rays, except as otherwise provided, and only when Injury occurs to sound natural teeth; (20) orthodontic braces or appliances; (21) any loss for which benefits are paid under state or federal worker's compensation, employers' liability, or occupational disease law; (22) charges which the Insured would not have to pay if the Insured did not have insurance; (23) a charge which is in excess of the Allowable Expense; (24) cosmetic surgery, except reconstructive surgery due to a covered Injury; (25) participation in semi-professional and professional sports, play or practice, or any related travel; (26) participation in practice or play of any sports activity, including travel to and from games and practice, unless specified in this policy; (27) assistant surgeon services, unless specified in this policy; (28) elective treatment or surgery that is not prescribed by a Physician and is not Medically Necessary, health treatment, or examination where no Injury is involved; (29) Pre-existing Conditions; (30) any Heart or Circulatory Malfunction; (31) loss caused by or resulting from nuclear radiation or the release of nuclear energy; (32) services or treatment incurred to the extent that they are paid or payable under any Other Insurance Plan; (33) services or treatment incurred to the extent that they are paid or payable under any automobile insurance policy without regard to fault. This exclusion does not apply in any state where it is prohibited; (34) travel in or upon: (a) a snowmobile; (b) any two or three wheeled motor vehicle; (c) any off-road motorized vehicle not requiring licensing as a motor vehicle in the jurisdiction where operated; (35) any Accident in which the Insured is operating a motor vehicle without a current and valid motor vehicle operator's license (except in a driver's education program); (36) treatment of temporomandibular joint (TMJ) disorders involving the installation of crowns, pontics, bridges or abutments or the installation, maintenance or removal of orthodontic or occlusal appliances or equilibration therapy.

**NATIONAL  
VOLUNTARY STUDENT ACCIDENT INSURANCE  
SCHEDULE OF BENEFITS**

<b>INPATIENT:</b>	<b>LOW OPTION</b>	<b>HIGH OPTION</b>
Room & Board	Semi-Private Room Rate/\$150 per day maximum	80% of Allowable Expense/Semi-Private Room Rate
Hospital Miscellaneous	Up to \$600 per day maximum	Up to \$1,200 per day maximum
Registered Nurse	75% of Allowable Expense	100% of Allowable Expense
Physician's Nonsurgical Visits	Up to \$40 first day; \$25 per day thereafter	Up to \$60 first day; \$40 per day thereafter
(Benefits are limited to one visit per day and do not apply when related to surgery)		
<b>OUTPATIENT:</b>		
Hospital Outpatient Surgery – Facility Charge	Up to \$1,000 maximum	Up to \$1,200 per day maximum
Physician's Nonsurgical Visits	Up to \$40 first day; \$25 per day thereafter	Up to \$60 first day; \$40 per day thereafter
(Benefits are limited to one visit per day and do not apply when related to surgery or physiotherapy)		
Physiotherapy	Up to \$30 first day; \$20 per day thereafter/5 day maximum	Up to \$60 first day; \$40 per day thereafter/5 day maximum
Emergency Room	Up to \$150 maximum	Up to \$300 maximum
(Use of room and supplies; treatment must be rendered within 72 hours from time of injury)		
X-Ray Services (Includes charges for reading)	\$200 maximum	\$600 maximum
Diagnostic Imaging - Cat Scan/MRI (includes charges for reading)	\$300 maximum	\$600 maximum
Laboratory	\$50 maximum	\$300 maximum
Injections	Up to \$25/injury	Up to \$25/injury
Prescription Drugs	\$75 maximum	\$200 maximum
Orthopedic Braces and Appliances	\$75 maximum	\$140 maximum
<b>INPATIENT AND/OR OUTPATIENT:</b>		
Surgeon's Fees	\$1,000 maximum. (No more than one procedure through the same incision will be paid)	\$1,200 maximum. (No more than one procedure through the same incision will be paid)
Anesthetist/Assistant Surgeon	20% of surgeon's allowance	25% of surgeon's allowance
Ambulance	\$300 maximum	\$800 maximum
Consultant	\$200 maximum	\$400 maximum
Treatment of Heat Exhaustion	100% of Allowable Expense	100% of Allowable Expense
Dental	Up to \$200 per tooth (Benefits are paid on sound natural teeth only)	Up to \$500 per tooth (Benefits are paid on sound natural teeth only)
Replacement of Eyeglasses, Contact Lenses and Hearing Aids	\$200 maximum (When broken as a result of a covered injury)	\$300 maximum (When broken as a result of a covered injury)

**PLAN & RATE OPTIONS**

(Make your selection on the enrollment form attached).

COVERAGE PLANS	LOW OPTION RATES	HIGH OPTION RATES
24-Hour	\$ 86.65	\$132.65
24-Hour Summer Only	\$ 22.45	\$ 35.30
At School	\$ 21.40	\$ 31.00
High School Football	\$147.65	\$230.05
Spring High School Football	\$ 58.85	\$ 92.00
Extended Dental	\$ 9.65	\$ 9.65

**RETAIN THIS DESCRIPTION FOR YOUR RECORDS.** Retain this student accident insurance flyer, and your canceled check, money order receipt or credit card receipt as your record of coverage. This flyer has been designed to illustrate the highlights of this insurance. All student accident insurance information is subject to the provisions of Policy Form SR2014 and state special versions. Exclusions and Limitations will apply. Should there be any discrepancy between the policy and this student accident information, policy provisions will prevail.





School District: \_\_\_\_\_

School Name: \_\_\_\_\_

Student ID #: \_\_\_\_\_

Policy Number: \_\_\_\_\_

**STUDENT CLAIM FORM**

- 1. Please fully complete this form
- 2. Attach itemized bills that includes Diagnosis and Procedure codes
- 3. Mail, E-mail or Fax to HSR

P.O. Box 250649  
 Plano, Texas 75025  
 Phone: (972) 512-5600 Fax: (972) 512-5818  
 Toll Free (866) 409-5734

E-mail: [K12claims@hsri.com](mailto:K12claims@hsri.com)

**PART I – POLICYHOLDER’S REPORT**

1. Claimant’s Name (injured/ill 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						7. Phone Number (include area code)			
8. Parent/Legal Guardian Name, Address, City, State & Zip						9. Phone Number (include area code)			
10. Date of Accident/Illness		11. Time of Accident <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.		12. Place where Accident Occurred			13. Date of First Treatment		
Dental Claims	14. Indicate which Teeth were Involved in the Accident				15. 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				
16. 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			
17. Describe How Accident Occurred or the Nature of the Illness – Give all possible details									
18. Which Best Describes the Activity:			<input type="checkbox"/> During lunch hour			<input type="checkbox"/> Athletic period			
<input type="checkbox"/> Play or practice of interscholastic sports			<input type="checkbox"/> In school bus			<input type="checkbox"/> On school property during school hours			
<input type="checkbox"/> Not school related			<input type="checkbox"/> School sponsored field trip			<input type="checkbox"/> School sponsored activity during school hours			
<input type="checkbox"/> P.E. class			<input type="checkbox"/> Traveling to/from school			<input type="checkbox"/> ROTC activity			
19. Name of Person Supervising the Activity					20. If engaged in an Interscholastic Sport at the time of the injury, what was the sport?				
Signature of Parent/Legal Guardian: X _____ Date: _____					Signature of School Official: X _____ 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, if applicable, 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 # \_\_\_\_\_

If applicable, claimant’s primary employer name, address, and phone number \_\_\_\_\_

If applicable, mother’s primary employer name, address, and phone number \_\_\_\_\_

If applicable, 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.

Signature of Parent/Legal Guardian: X _____ Date: _____		Signature of Witness: X _____ Date: _____	
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**PART III – AUTHORIZATION TO PAY BENEFITS TO PROVIDER**

I hereby authorize medical payments to be made directly to doctor(s), hospital(s), or indicated provider(s) of service(s) in connection with this claim. (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 \_\_\_\_\_

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.

**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.**

## FRAUD WARNING NOTICES

**Any person who knowingly presents a false or fraudulent claim for payment of 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.**

### STATE SPECIFIC PROVISIONS

<b>Alabama</b>	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.
<b>Alaska</b>	A 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.
<b>Arizona</b>	<b>For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.</b>
<b>Arkansas Louisiana</b>	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.
<b>California</b>	For your protection California law requires the following to appear on this form: Any person who knowingly presents 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.
<b>Colorado</b>	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 policyholder or claimant, for the purpose of defrauding or attempting to defraud the policyholder 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.
<b>Connecticut</b>	This form must be completed in its entirety. Any person who intentionally misrepresents or intentionally fails to disclose any material fact related to a claimed injury may be guilty of a felony.
<b>Delaware Idaho</b>	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.
<b>District of Columbia</b>	WARNING: It is a crime to provide false or misleading information to an insurer, for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.
<b>Florida</b>	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 of the third degree.
<b>Hawaii</b>	For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.
<b>Indiana</b>	A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.
<b>Kentucky</b>	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.
<b>Maine</b>	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.
<b>Maryland</b>	Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
<b>Michigan North Dakota South Dakota</b>	Any person who knowingly and with intent to defraud any insurance company or another 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 and subject the person to criminal civil penalties.
<b>Minnesota</b>	A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.
<b>Nevada</b>	Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under state or federal law, or both and may be subject to civil penalties.
<b>New Hampshire</b>	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 RSA 638:20.
<b>New Jersey</b>	Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.
<b>New Mexico</b>	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 civil fines and criminal penalties.
<b>New York</b>	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 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.
<b>Ohio</b>	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.
<b>Oklahoma</b>	WARNING: Any person who knowingly, and with 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.
<b>Oregon</b>	Any person who knowingly and with intent to defraud or solicit another to defraud an insurer: (1) by submitting an application, or (2) by filing a claim containing a false statement as to any material fact thereto, may be committing a fraudulent insurance act, which may be a crime and may subject the person to criminal and civil penalties.
<b>Pennsylvania</b>	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.
<b>Rhode Island West Virginia</b>	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.
<b>Tennessee Virginia Washington</b>	It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fine and denial of insurance benefits.
<b>Texas</b>	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.
<b>Utah</b>	Any person who knowingly presents false or fraudulent underwriting information, files or causes to be filed a false or fraudulent claim for disability compensation or medical benefits or submits a false or fraudulent report or billing for health care fees or other professional services is guilty of a crime and may be subject to fines and confinement in state prison. Utah Workers Compensation claims only.

Listed below are important instructions and comments about filing a claim.

#### YOUR CLAIM FORM

1. This claim form should be fully completed and submitted within 90 days from the date of injury. Be sure to answer and complete the section regarding “**OTHER INSURANCE STATEMENT**”, marking either yes or no, and signing the line for authorization, so that *HSR* and the doctors/hospital may communicate concerning your claim.  
**Incomplete claim forms are one of the most frequent reasons why claim payments are delayed.**
2. Only one claim form for each accident needs to be submitted.
3. Once completed, make a photocopy for your records, and mail to the address shown below.
4. **DO NOT** assume that anyone else will mail this claim form to *HSR* for you.

#### YOUR BILLS

1. Please advise all doctors/hospitals regarding this coverage so they may forward us their itemized bills.
2. If you have already been to the doctor/hospital and did not know about this coverage, then please send all of the itemized bills to *HSR* at the address shown below.
3. **The bills should include the name of the doctor/hospital, their complete mailing address, telephone number, the date you were seen by the doctor/hospital, what the doctor saw you for (diagnosis) and the specific itemized charges (description of treatment and amount) incurred (including the CPT/procedure code).**
4. If this information is not on the bill you submit for payment *HSR* will request from the doctor/hospital which will delay the review of your claim. In some cases, the medical providers will not provide the requested information to *HSR* due to HIPPA. Ultimately, it is your responsibility to provide the proper documentation. “Balance Due” or “Balance Forward” statements do not contain sufficient information to complete your claim. *HSR* can not pay your bills using only the Primary Insurance Carrier’s EOB.

#### EXCESS INSURANCE

1. This policy provides coverage on a secondary/excess basis. If you have any other primary insurance coverage you need to send the bills to your primary insurance first.
2. *HSR* will consider benefits after your other, primary insurance has processed the claim.
3. We will require a copy of your primary insurance Explanation of Benefits (EOB) which you should receive from your primary insurance letting you know what was paid or denied, and the reason(s) why.
4. *HSR* will not be able to consider your claim without this information.

If you have any questions, please contact Customer Service at (866) 409-5734. They are available from 8:00 a.m. thru 5:00 p.m. central time, Monday – Friday. You may also forward any documents by fax to (972) 512-5818.

***Health Special Risk, Inc.***  
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