Gerber Life Insurance Company

CLAIM FORM
SIGNED CLAIM FORM IS REQUIRED

1. **PLEASE FULLY COMPLETE THIS FORM PAGE 1 & PAGE 2**
2. **ATTACH HCFA/UB04-MEDICAL BILLS & EOBS FROM ANY OTHER INSURANCE YOU HAVE**
3. **SEND ALL CORRESPONDENCE TO:**

WEB-TPA
P.O. Box 2415
Grapevine, TX 76099-2415

Toll-Free: 866-975-9468
Fax: 469-417-1969
Email: benefit.assist@webtpa.com
File Electronically: Click Here

IMPORTANT NOTICE:
This plan of insurance is secondary, in most instances, to any health insurance you have. If you have other insurance, submit your claim (health and/or dental) to your other insurer. When you receive their Benefit Statement, send it to us along with your HCFA/UB04 (medical bills) and this completed form. Note: **The accident policy benefits are limited and may not provide 100% coverage.**

⮜ IF PART 1-A & PART 1-B ARE NOT COMPLETED IN FULL THIS CLAIM CANNOT BE PROCESSED AND WILL BE RETURNED ⮞

PART 1-A – TO BE COMPLETED IN FULL BY THE ORGANIZATION/SCHOOL

Organization/School District/College Name White Mountains School District SAU #35 Policy Number 29-5010-23

School/Team/League Name _____ Phone No. ( )_____

Address _____ Email _____

_____ Type of Activity/Sport _____

If Athletics, designate ☐P.E. Class ☐Intramural ☐Interscholastic ☐Intercollegiate ☐Game ☐Jr. Varsity ☐Varsity ☐Youth ☐Adult ☐Practice ☐Other _____

Name of injured person/student _____

Date of Accident _____ Accident Time _____

Date of First Treatment _____Has treatment been completed? ☐Yes ☐No

Where and how did accident occur? (Please be specific) _____

_____

_____

_____

Part of body Injured _____ ☐Right or ☐Left At the time of the accident, was the claimant involved in a sponsored and supervised activity and were they a current student/member of the Organization/School District? ☐Yes ☐No

Under whose supervision? _____ Was he/she a witness? ☐Yes ☐No

Authorized Signature _____ Title _____ Date _____

(MUST BE SIGNED BY AN ORGANIZATION/SCHOOL OFFICIAL UNLESS INJURY DID NOT OCCUR DURING AN ORGANIZATION/SCHOOL ACTIVITY. SIGNATURE IS REQUIRED)

PART 1-B – TO BE COMPLETED IN FULL BY CLAIMANT – OR BY PARENT/LEGAL GUARDIAN IF CLAIMANT IS A MINOR

Injured Party/Student Legal Name _____ Preferred/Nickname:_____

Date of Birth _____ Age _____ Grade Level _____ ☐Male ☐Female

Claimant is a ☐Student ☐Player ☐Coach ☐Official/Umpire ☐Volunteer ☐Child Care ☐Participant ☐CE Student (# of credits____)

Address of Injured Person or Parents/Guardian _____

_____

Phone No. ( )_____ Email Address _____

If Injured party is over age 18: Employer Name and Address _____

_____

Phone No. ( )_____ ☐Self Employed ☐Unemployed

Father/Guardian Name _____

Employer Name and Address _____ Phone No. ( )_____

_____ ☐Self Employed ☐Unemployed

PLEASE CONTINUE TO THE NEXT PAGE OF THE FORM WHICH MUST BE COMPLETED IN FULL

Mother/Guardian Name _____

Employer Name and Address _____ Phone No. ( )_____

_____ ☐Self Employed ☐Unemployed

If Dental Injury: Please submit verification from the dentist that the tooth/teeth are whole, sound and natural.

Is claimant covered under any other medical and or dental insurance policy? ☐Yes ☐No

Is claimant covered under a government sponsored insurance such as Medicare/Medicaid? ☐Yes ☐No

Name of all companies providing claimant insurance coverage or prepaid health plans

Name of Company	**Address**	**Policy #**

Are benefits due for this claim under these other insurance coverages? ☐Yes ☐No **(See IMPORTANT NOTICE at top of form on page 1)**

Does your son or daughter have medical insurance coverage as an eligible dependent from a previous marriage as mandated in a divorce decree? ☐Yes ☐No If yes, please give name, address and phone number of responsible party _____

_____

AFFIDAVIT: I verify that the above statement on other insurance is accurate and complete. I understand that the intentional furnishing of incorrect information via the U.S. Mail may be fraudulent and violate federal laws as well as state laws. I agree that it is determined at a later date that there are other insurance benefits collectible on this claim I will reimburse Gerber Life Insurance Company to the extent for which Gerber Life Insurance Company would not have been liable.

Signature: Injured Person, Parent or Guardian _____ Date: _____

SIGNATURE IS REQUIRED

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize any employer, health plan, insurance company, hospital, physician, health care profession, clinic, laboratory, pharmacy, medical facility or other person that has provided treatment, payment, or services in connection with this claim to disclose, when requested to do so, all information with respect to any injury, policy coverage, medical history, consultations, prescription or treatment, and copies of all hospital or medical records and itemized bills to WebTPA, Inc. and Gerber Life Insurance Company, it's agents, employees and representatives.

I hereby authorize WebTPA, Inc. to discuss any information related to medical expenses incurred or treatments rendered in connection with this claim, with Special Markets Insurance Consultants, Inc. representatives and their assigned agents and to officials at the school or organization through which this policy is issued. A photo static copy of this authorization shall be considered as effective and valid as the original.

Signature: Injured Person, Parent or Guardian _____ Date: _____