



ACCIDENT INSURANCE SOLUTIONS

Health Special Risk, Inc.

8400 Belleview Drive, Suite 150

Plano, Texas 75024

Payor ID# 65449

Toll Free (866) 523-3199

Fax: (972) 512-5820

CHUBB

Underwritten by: Federal Insurance Company

Policy Number:

9912-84-33

Policy Name:

RefQuest, LLC

Class No:

1. Please fully complete this claim form
2. Attached Itemized Bills
(UB04 or CMS HCFA 1500 bill)
3. Mail, fax or email to Health Special Risk, Inc.
- E-mail: Chubbclaims@hsri.com

PART I – POLICYHOLDER’S REPORT

1. Claimant’s Name (Injured Person)		2. Social Security Number - -		3. Gender ☐ M ☐ F		4. Birthday __ / __ / __		5. E-Mail	
6. Address of Injured Person and Best Contact Phone Number (Include Area Code)									
7. Date and Time of Accident		8. Place where Accident Occurred			9. Was injured person a participant, staff member, guest, or volunteer?				
Dental Claims	10. Indicate which Teeth were Involved in the Accident			11. Describe Condition of Injured Teeth Prior to Accident: ☐ Whole, Sound, and Natural ☐ Filled ☐ Capped ☐ Artificial					
12. Nature of Injury (Indicate Part of Body Injured – e.g., broken arm, sprained ankle, etc.)					Did Injury Result in Death? ☐ YES ☐ NO				
13. Describe How Accident Occurred – Give All Possible Details – Must be a Bodily Injury Due to Accident									
14. Did Accident Occur (Check Yes or No for Each of the Following):									
A. During a policyholder programmed, sponsored & supervised, or sanctioned activity?					☐ YES ☐ NO				
B. On activity premises?					☐ YES ☐ NO				
C. While on the job (if applicable)?					☐ YES ☐ NO				
D. While traveling directly and uninterruptedly to or from home and policyholder premises?					☐ YES ☐ NO				
15. Name of Event or Activity					16. Name and Title of Supervisor				
17. Signature of Policyholder Representative					18. Title of Policyholder Representative			19. Date	

PART II – OTHER INSURANCE STATEMENT

Do you 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? ☐ YES ☐ NO

If Yes, name of insurance company _____ Policy # _____

Name of insurance company _____ Policy # _____

Claimant’s primary employer name, address, and phone number _____

Spouse’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.

New York Fraud Warning Notice: 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.

SIGNATURE OF PARTICIPANT

DATE

PART III – AUTHORIZATION TO PAY BENEFITS TO PROVIDER

I authorize medical payments to physician or supplier for services described on any attached statements enclosed. (Otherwise please 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

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.

8400 Belleview Drive, Suite 150
Plano, Texas 75024
Phone: (972) 512-5600 Fax: (972) 512-5820
Toll Free: (866) 523-3199
E-mail : HSRDisability@hsri.com

APPLICATION FOR DISABILITY BENEFITS
(To Avoid Delay, Please Answer All Questions)
**Form Must be Completed in Full
to Process Benefits**

Policy Number: 9912-84-33

Policy Name: RefQuest, LLC

Class No:



PART I – CLAIMANT’S REPORT

1. Claimant's Full Name (last, first, middle)	2. Social Security Number - -	3. Gender _M _F	4. Birthday _ / _ / _	5. E-Mail
6. Claimant's Address (street, city, state, zip) and Best Contact Phone Number (include area code)			7. Date of Accident	

PART II – ATTENDING PHYSICIAN’S STATEMENT

1. Diagnosis and Concurrent Conditions use ICD-9/10 code(s) or give name(s)		2. Is this condition due to injury arising out of patient's employment? ☐ Yes ☐ No	
3. Date Symptoms First Appeared		4. Date Patient First Consulted You for this Condition	
5. Has Patient ever had Same or Similar Condition? ☐ Yes ☐ No (If yes, when and describe)			
6. Name, Address, and Best Contact Phone Number of Referring Physician			
7. Is Patient Totally Disabled (unable to work)? If so, indicate the date(s) the patient is totally disabled. From: _____ Through: _____		8. Is Patient Partially Disabled? If so, indicate the date(s) the patient is partially disabled. From: _____ Through: _____	
9. If Still Disabled, Date Patient Should be Able to Return To Work		10. Is Patient Still Under Your Care for this Condition? ☐ Yes ☐ No	
11. Physician's Best Contact Phone and Fax Numbers (include area code) and E-Mail Address			
12. Physician's Address (street, city, state, zip)			
13. Physician's Name (Printed)	14. Physician's Signature		15. Date

*Every 4 weeks we will request an update on your disability status from your physician. This is required in order to prevent a delay in payment.

By entering your name above, 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

Alabama	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.
Alaska	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.
Arizona	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.
Arkansas	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.
Louisiana	
California	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.
Colorado	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.
Connecticut	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.
Delaware	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.
Idaho	
District of Columbia	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.
Florida	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.
Hawaii	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.
Indiana	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.
Kentucky	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.
Maine	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.
Maryland	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.
Michigan	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.
North Dakota	
South Dakota	
Minnesota	A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.
Nevada	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.
New Hampshire	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 RSA638:20
New Jersey	Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.
New Mexico	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.
Ohio	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.
Oklahoma	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.
Oregon	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.
Pennsylvania	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.
Rhode Island	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.
West Virginia	
Tennessee	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, fines and denial of insurance benefits.
Virginia	
Washington	
Texas	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.
Utah	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.

HOW TO FILE A CLAIM

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. The claim form must be signed by a policyholder representative.
3. Only one claim form for each accident needs to be submitted.
4. Once completed, make a photocopy for your records, and mail to the address shown below.
5. 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 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 including the CPT/procedure code). Contact your medical provider for a UB04 or HCFA 1500 billing form.**
4. Due to HIPAA Privacy laws **HSR** is unable to request this information from your medical provider. 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** cannot pay your bills using only the Primary Insurance Carrier’s EOB.

EXCESS INSURANCE

1. If this policy provides coverage on a secondary/excess basis and 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 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. **HSR** will not be able to consider your claim without this information

If you have any questions, please contact Customer Service at (866) 523-3199. They are available from 8:00 a.m. to 5:00 p.m. Central time, Monday – Friday. You may also forward any documents by fax to (972) 512-5820 or email to Chubbclaims@hsri.com.

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