KNOX COUNTY PARKS AND RECREATION
CLAIMS FILING INSTRUCTIONS
CLAIMS BEGINNING AUGUST 01, 2009

KNOX COUNTY CARRIES ACCIDENT SUPPLEMENTAL MEDICAL INSURANCE FOR ATHLETES WHICH COVERS MEDICAL EXPENSES RELATED TO INJURIES SUSTAINED DURING SPONSORED TRY-OUTS, SPONSORED PRACTICES, AND SCHEDULED GAME OR EVENT OF THE SPORTS ACTIVITY. THIS IS AN EXCESS POLICY.

THIS POLICY PAYS ONLY THE REASONABLE, USUAL, AND CUSTOMARY CHARGES THAT ANY OTHER INSURANCE DOES NOT PAY. EXAMPLE : PARENT / GUARDIAN PRIMARY HEALTH INSURANCE. $ 0 DEDUCTIBLE APPLIES / $10,000 MAXIMUM MEDICAL BENEFIT / EACH ACCIDENT 1 YEAR MAXIMUM BENEFIT COVERAGE / SUBJECT TO LIMITATIONS SPECIFIED IN ORIGINAL POLICY YOUR CLAIM FOR BENEFITS WILL RECEIVE OUR EARLIEST POSSIBLE ATTENTION IF YOU FOLLOW ALL INSTRUCTIONS COMPLETELY AND PROMPTLY.

YOUR CLAIM WILL BE DENIED IF THE CLAIM FORM ATTACHED IS NOT RECEIVED WITHIN 90 DAYS OF THE ACCIDENT
SEND THE COMPLETED CLAIM FORM IMMEDIATELY
MAKE COPIES OF EVERYTHING

1. SUBMIT ALL CHARGES TO YOUR PRIMARY INSURANCE COMPANY. YOU WILL NEED TO OBTAIN **CMS 1500** OR **UB 04 FORMS.** FOR EACH CHARGE FROM YOUR HEALTHCARE PROVIDER. YOU MUST CONTACT THE BUSINESS OFFICE OF EACH PROVIDER TO SEND THESE FORMS TO YOU. YOU WILL RECEIVE AN **"EXPLANATION OF BENEFITS"** LATER FROM YOUR INSURANCE COMPANY.
2. ATTACHED CLAIM FORM PART A - MUST BE COMPLETED BY COACH OR SUPERVISOR OF ACTIVITY AND SIGNED.
3. ATTACHED CLAIM FORM PART B - MUST BE COMPLETED BY PARENT OR GUARDIAN IN FULL AND SIGNED
4. **SEND THE COMPLETED AND SIGNED CLAIM FORM TO :**

KNOX COUNTY PARKS AND RECREATION
2447 SUTHERLAND AVENUE
KNOXVILLE, TN 37919

5. **CONTACT LOOMIS BENEFITS AT 866-915-6618 FOR STATUS OF CLAIMS**

**** COACHES DO NOT HAVE ACCESS TO YOUR CLAIM INFO.**
REMEMBER THIS IS AN EXCESS POLICY. YOU MAY NEED TO MAKE ARRANGEMENTS WITH THE PROVIDER FOR PAYMENT FOR TREATMENT DURING THE TIME YOUR CLAIM IS BEING PROCESSED

LOCAL AGENT – MIKE BELL
CONSOLIDATED INSURANCE SERVICES

Phone (865) 675-9494
TN WATS 800-467-9490

NOTICE

WARNING: 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 may be a crime.

PART A – This PART **MUST** be **completed, dated** and **signed** by an official or the Organization.

1. Name of Organization (Policyholder)
KNOX COUNTY PARKS & RECREATION

2. Policy No.

3. Name of Organization or Team (if different from Policyholder)

4. Address of Organization (Street) (City) (State) (Zip)

5. Name of Injured Person (Insured) (First) (Middle) (Last)

6. Date of Accident/Injury Mo Day Year / /	7. Injury Occurred: Practice ☐ Travel ☐ Game ☐ Other ________________________________	8. Type of Sport or Activity:

9. Explain HOW the accident and injury occurred. NOTE: If your organization uses an Accident Report form, attach a copy of the Report.

10. Describe the nature of injury.

11. At the time of the accident, was the Injured Person involved in an activity under the jurisdiction of the Organization (Policyholder)? Yes ☐ No ☐	12. Name of Supervisor of Activity	13. Was he/she a witness to Yes ☐ No ☐

14. Signature of Organization Official **X** ________________________________	15. Title of Official	16. Area Code/Telephone No.	17. Date Signed

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. or Student Visa No. / /	4. Area Code/Telephone No. ( )

5. Address (Street) (City) (State) (Zip)

6. Employer (Name) (Street) (City) (State) (Zip)

7. 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 of Other Insurance Company(s)	Policy Number(s)	Name of Policyholder(s)

8. If the Injured Person is under 18 or otherwise dependent, give the following information:

Name of Father or Male Guardian   Social Security No. / /

Place of Employment

Address of Employer   Area Code/Employer Phone No. ( )

Name of Mother or Female Guardian   Social Security No. / /

Place of Employment

Address of Employer   Area Code/Employer Phone No. ( )

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

Name of Father or Male Guardian   Social Security No. / /

Place of Employment

Address of Employer   Area Code/Employer Phone No. ( )

I hereby authorize any physician or medical practitioner, hospital, other organization, institution, or person that has any medical records or knowledge of me or my family as diagnosis, treatment, and prognosis regarding any physical, mental, drug or alcohol condition of any and all such information to be given to Berkley Group Companies: StarNet Insurance Company, Acadia Insurance Company, Great Divide Insurance Company or its authorized Administrator or their legal representatives. Any information obtained will not be released by the Company except to persons or organizations performing business or legal services in connection with my application or claim. A photocopy of this authorization shall be valid as the original and is valid for 24 months from the date shown below. I understand that my authorized representative or I will receive a copy of this authorization upon request.

X ______________________________   ____________________

Signature (in writing) of Responsible Party   Print Name

Check one: ☐ Injured Person ☐ Parent ☐ Guardian   Date: ____________