SCHOOL'S REPORT OF ACCIDENT

Complete this form and return within 90 days of the accident. Please send **itemized** bills only; balance due bills cannot be processed. Only one form is necessary per accident. Show school name and policy number on additional bills.

Send this claim form, PRIMARY INSURANCE EXPLANATIONS OF BENEFITS, and ITEMIZED BILLS to:

A-G ADMINISTRATORS, INC.

P.O. BOX 979, VALLEY FORGE, PA 19482

Fraud Warning: Any person who, knowingly and with intent to defraud, or helps commit a fraud against, any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits or may be committing a fraudulent insurance act, which is a crime and subjects such person to criminal and/or civil penalties. For residents of the following states, please see end of the form: California, Colorado, District of Columbia, Florida, New York, Tennessee, Texas or Virginia.

Name of School		Policy No.	STUDENT'S SOCIAL SECURITY NUMBER
School System		Name of Student	
Student Covered: 🔲	Schooltime 🔲 24 Hr. 🔲 Dental 🔲 All Sports 🛄 arent or Guardian	Football Student's Birthdate	Grade
1. Date & Time of Accident	AM PM	2. COMPLETE details of accident_	
4. Did accident occur (a) Attending school (b) Traveling to or (c) Engaged in a sc	while: olduring hours and days school in session? No rom school? No Yes If yes, was student on us hool sponsored and supervised activity? No Yes An reticipating in an Intramural sport? No Yes An	sual and direct route? 🔲 No 🔲 Yo'es Name & place of activity	98
	es of attending physicianse above answers are complete, true, and correct to t		ef.
SIGNATURE OF SCHO	OL OFFICIAL (Required on all claims except 24 hour coverage)	TITLE	DATE
SIGNATURE OF PARE	NT OR GUARDIAN (Parent please complete reverse side of cl	aim form)	DATE
PHYSICIAN'S	OR DENTIST'S REPORT		
Nature of Injury 3. Has patient ever ha	d the same or similar condition? 🔲 No 🔲 Yes If ye		2. Date of First Treatment
4. Nature of Surgical	Procedure, if any & procedure code		
	Description:		Charge:
6. Has patient been d	scharged from treatment? No Yes If yes, give	date	TOTAL
•	d to a hospital? No Yes If yes, give name & ad		CHARGE:
8. TO WHAT OTHER I	NSURANCE COMPANY HAVE YOU REPORTED THIS C	LAIM? (INCLUDE NAME & ADDRESS)	e228888888888
9. List teeth involved	and indicate on chart		### ### ### ### ### ### ### ### ### ##
	of injured teeth prior to accident. 2. FILLED 🔲 3. WHOLE 🔲 4. CAPPED OR ARTIFI	ICIAL 🔲 5. SOUND & NATURAL	32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17
Number as required b	REQUIREMENT: Insert your Tax Identification by Section 6041 of the Internal Revenue Code. SSED WITHOUT THIS INFORMATION.)		COMPANY USE ONLY
PHYSICIAN'S SIGNAT	JRE	DATE	
PHYSICIAN'S NAME AND ADDRESS			
AND ADDITEOU	NAME (PLEASE PRINT OR TYPE) ADDRE	ESS	

HOSPITAL REPORT (ATTACH ITEMIZED HOSPITAL BILL, IF ANY)

THIS SECTION MUST BE COMPLETED BY PARENT OR GUARDIAN							
IF BLUE CROSS (HOSPITALIZATION) GROUP # CONTRACT #	SERVICE CODE #	IF BLUE SHIELD (PHYSICIAN'S CARE GROUP # CONTRACT #		SERVICE CODE #			
NAME & ADDRESS OF MOTHER'S EMPLOYER	NAME & ADDRESS OF FATHER'S EMPLOYER						
DO YOU HAVE MEDICAL INSURANCE OTHER THAN BLUE CROSS? Yes No	IF SO, NAME OF COMPANY			POLICY NUMBER			
ADDRESS OF OTHER INSURANCE COMPANY	TYPE OF PLAN FROM THIS COMPANY Individual Group						
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. I agree that if it is determined at a later date that there are other insurance benefits collectible on this claim I will reimburse the school's insurance company to the extent of any amount collectible.							
SIGN: Parent or Guardian	Date						
If Insured is hospital confined, please complete AUTHORIZATION below and return immediately to eliminate any delay in completion of claim. AUTHORIZATION I authorize any physician and/or hospital to release such information as relates to this claim to The Insurance Company or the Company's authorized Claims Administrator.							
Signature	Date						
AUTHORIZATION TO PAY BENEFITS TO PROVIDER I authorize payment of Medical payments to Physician or Supplier for Services described on the reverse side.							
SIGN: Parent or Guardian		Date					

FRAUD WARNING

California & Texas Residents: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is quilty of a crime and may be subject to fines and confinement in state prison.

Colorado Residents: 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 from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

District of Columbia Residents: 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 Residents: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

New York Residents: 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.

Tennessee Residents: 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 Residents: Any person who, with the 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 may have violated state law.