NOTIFICATION OF INJURY

This Notification of Injury Form is to be used for accident medical claims. **This form and all other correspondence must be submitted within 90 days from the date of accident.**

Policies With Excess Coverage
Eligible covered expenses will be paid only if they are in excess of other valid and collectible insurance or medical payment plan. If the claimant is covered by any other health insurance or medical payment plan they must first submit claim to the primary insurance. After the primary insurance has paid benefits, then submit this claim form along with all EOB's (explanation of benefits) from the primary insurance.

Policies With Primary Coverage
Eligible covered expenses will be paid regardless of other valid and collectible insurance or medical payment plan. There is no need to submit claim to any other insurance.

Claim Form
This Company claim form must be submitted for each individual claim. Part (A) must be completed in full by the Policyholder official or a staff member and signed by the Policyholder official or staff member. Part (B) must be completed in full by the injured person or the parent or guardian if that injured person is a minor and also must be signed. A fully completed claim form is not necessary when submitting additional medical bills; only one claim form is needed per accident/injury.

Medical Bills
Attach all medical bills. All submitted medical bills must be itemized for service. A balance due statement is not acceptable and will only delay processing. A physician's office should submit an invoice per CMS 1500. A hospital and/or emergency room should submit an invoice per UB04. CMS 1500 and UB04 are universal billing forms supplied by the physician's office and/or hospital.

Information Requests
In the event that a claim is not submitted in full or if additional information is needed, the claim will be closed, and the additional information will be requested via US Mail. Please forward the requested information immediately, so that we may finish adjudicating your claim in a swift manner. The explanation of benefits (information request) will be sent to the address of the injured person listed on the claim form in Part (B).

Claim Submission Checklist
Use the below checklist to assure a properly submitted medical claim is to be sent.

If the injured person has primary health insurance has the claim been submitted first to the primary health insurance company? ☐ Yes ☐ No

If claim has first been submitted to the primary health insurance company, are copies of EOB's (explanation of benefits) attached? ☐ Yes ☐ No

Is part (A) of the claim form completed by the Policyholder official or staff member and signed? ☐ Yes ☐ No

Is part (B) of the claim form completed by the injured person and signed? ☐ Yes ☐ No

Are the attached medical bills itemized in either a CMS 1500 or UB04 form? ☐ Yes ☐ No

Is part (B), item number 3 (social security number) completed? ☐ Yes ☐ No

Mailing The Claim
When completed in full, mail the attached completed claim form, itemized medical bills and copies of EOB's (explanation of benefits for use if coverage is excess) to:

The Loomis Company
P.O. Box 14162
Reading, PA. 19612-4162

If you should have any questions, or if a physician's office or hospital needs to confirm benefits before a medical procedure, please contact the claims office at (866) 915-6618.

Documents may also be faxed to the claims office at (610) 370-6767. Please do not fax full medical claims, as often times medical bills are illegible when faxed. For emailing documents, please email suppacc@loomisco.com

PLEASE NOTE: Claims Must Be Submitted Within 90 Days Of The Date Of Accident.

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.

<table>
<tr><td colspan="4">**PART A** – This PART **MUST** be **completed, dated** and **signed** by an official or the Organization.</td></tr>
<tr><td colspan="4">1. Name of Organization and Policy Number</td></tr>
<tr><td colspan="4">2. Address of Organization (Street) (City) (State) (Zip)</td></tr>
<tr><td colspan="4">3. Name of Injured Person (Insured) (First) (Middle) (Last)</td></tr>
<tr><td>4. Date of Accident/Injury
Mo Day Year
/ /</td><td colspan="2">5. Injury Occurred:
Practice ☐ Travel ☐ Game ☐
Other _____</td><td>6. Type of Sport or Activity:</td></tr>
<tr><td colspan="4">7. Explain HOW the accident and injury occurred. NOTE: If your organization uses an Accident Report form, attach a copy of the Report.

7b. Please indicate body part injured:</td></tr>
<tr><td>8. At the time of the accident, was the Injured Person involved in an activity under the jurisdiction of the Organization (Policyholder)? Yes ☐ No ☐</td><td>9. Name of Supervisor of Activity</td><td colspan="2">10. Was he/she a witness to
Yes ☐ No ☐</td></tr>
<tr><td>11. Signature of Organization Official
X _____</td><td>12. Title of Official</td><td>13. Area Code/Telephone No.
( )</td><td>14. Date Signed</td></tr>
</table>

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. ( )

Please note the Injured Person's Social Security Number MUST be provided as required by the Center for Medicare Services.

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

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

Area Code/Employer Telephone No.
( )

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

Place of Employment

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

Name of Mother or Female Guardian

Place of Employment

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

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

Name of Wife or Husband

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: Berkley Life and Health Insurance Company, 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.

☐ Injured Person
☐ Parent
☐ Guardian

X _____ _____ Date: _____

Signature (in writing) of Responsible Party Print Name