How to File a Medical Claim

Florida College System Risk Management Consortium

Attached is a Blanket Lines Notice of Claim (Claim Form) for your accident policy.

Please forward claims and questions to the following address:

Fringe Benefit Coordinators, Inc.
P. O. Box 5249
Gainesville, FL 32627-5249
Toll Free Number (800) 654-1452
Fax Number (352) 372-9805

Policy underwritten by Hartford Life and Hartford Life and Accident Insurance Company
Claimant administration handled by Fringe Benefit Coordinators, Inc.

Step 1 - Submit a completed Notice of Claim (claim form) to our office either by fax or mail.

The Policyholder (not the Parent, Claimant or Agent) should:

- Fully answer/sign each item in the Policyholder Certification section.
- Read and sign the Fraud Warning Certification statement located on the reverse side of the Notice of Claim.

The Parent/Guardian or Adult Claimant should:

- Fully answer/sign each item in the Claimant Certification section (choose either the Parent/Guardian column or the Adult Claimant column; which ever is applicable).
- Read and sign the Fraud Warning Certification statement located on the reverse side of the Notice of Claim.

Step 2 - Submit itemized medical bills for payment consideration to our office. This policy is Excess, so please also include any other insurance carrier's corresponding Explanation of Benefits (EOBs) as outlined in the helpful information bullet listed below.

Helpful information for submitting claims and expediting payment

- A fully completed Notice of Claim is required for each accident/injury a Claimant incurs. Claims submitted with incomplete information will be denied pending receipt of the missing data.
- Release of claim forms by an insurance company is not an admission of coverage. In addition, information on the form is subject to audit by the insurance company.
- Providers may wish to bill us directly for their services. If they do, please ensure a Notice of Claim has first been submitted to our office.
- Itemized medical bills (including claimant name, date of service, diagnosis, procedure codes, amount charged, and provider information) should be submitted for processing. "Balance Due" statements and/or incomplete bills do not provide enough claim detail to process the charges. In order to ensure we receive complete claim information, we suggest providers submit standardized billing statements (called "UB-04" for hospital charges and/or a "CMS-1500" for physician charges).
- Unless proof of payment is submitted with the medical bill (a copy of check, a medical bill that indicates the claimant has made all or partial payment or zero balance information) claim payment is generally sent directly to the medical providers.

Please detach this page and forward the completed Notice of Claim (and medical bills if you are submitting expenses for payment) to the address listed above. We recommend you keep copies of the correspondence you are submitting to use for future reference.

Clear Form

HARTFORD LIFE INSURANCE COMPANY
HARTFORD LIFE & ACCIDENT INSURANCE COMPANY
Notice of Claim

Florida College System Risk Management Consortium

Fringe Benefit Coordinators, Inc. P. O. Box 5249, Gainesville, FL 32627-5249
Toll Free Number (800) 654-1452 Fax Number (352) 372-9805

THE HARTFORD

POLICYHOLDER CERTIFICATION - To be completed by Policyholder Official

Policyholder Number	Policyholder Name
08SR213114	**Florida College System Risk Management Consortium**

College Name	College Phone Number ( )
Policyholder Address (Street, City, State & Zip Code) **4500 NW 27th Avenue, Suite D2, Gainesville, FL 32606**	Program Name
Claimant (Injured Party) Name	Time of Accident (hh:mm) _____ ☐ AM ☐ PM

Date of Accident: (mm/dd/yyyy)	Place of Accident	Cause of Accident
Indicate injured body part(s)	Nature of Sickness (if applicable)	Date Sickness first commenced

Policyholder Certification Signature Required:

I hereby certify the Claimant is a member of the group insured under the above Policy and the injury/sickness was sustained under adequate supervision while participating in an official Covered Activity. I further certify I have **read and signed** the Fraud Warning statement located on the reverse side of this form.

Title of Policyholder Official _____ Signature of Policyholder Official _____ Date _____

CLAIMANT/STUDENT CERTIFICATION - To be completed by Parent/Guardian or Adult Claimant

**Due to new government regulations, claims submitted without this data will be returned.*

***Parent/Guardian* completes for dependent child**		***Adult Claimant* completes**	
Claimant (Dependent Child) Name	Claimant Gender ☐ Male ☐ Female	Claimant Name	Claimant Gender ☐ Male ☐ Female
*Is the Claimant a Medicare Beneficiary? ☐ No ☐ Yes If yes, please provide Claimant's Social Security Number or Health Identification Claim Number _____		*Is the Claimant a Medicare Beneficiary? ☐ No ☐ Yes If yes, please provide Claimant's Social Security Number or Health Identification Claim Number _____	
Claimant Date of Birth	Daytime Phone Number ( )	Claimant Date of Birth	Daytime Phone Number ( )
Claimant Address (Street Number, City, State, Zip)		Claimant Address (Street Number, City, State, Zip)	
Does the Claimant have medical coverage through?		Do you have medical coverage through?	
Mother's employers policy*	☐ Yes ☐ No	Your employer*	☐ Yes ☐ No
Father's employers policy*	☐ Yes ☐ No	Spouse's employer*	☐ Yes ☐ No
Guardian's employers policy*	☐ Yes ☐ No	Medicare policy	☐ Yes ☐ No
Medicare policy	☐ Yes ☐ No	Medicaid policy	☐ Yes ☐ No
Medicaid policy	☐ Yes ☐ No	Any other medical policy*	☐ Yes ☐ No
Any other medical policy*	☐ Yes ☐ No		
This Policy is Excess, please include the other insurance carrier's Explanation of Benefits (EOBs) for each medical bill submitted.		This Policy is Excess, please include the other insurance carrier's Explanation of Benefits (EOBs) for each medical bill submitted.	

Parent/Guardian or Adult Claimant Certification Signature Required:

I certify the above information to be true and accurate to the best of my knowledge. I further certify I have **read and signed** the Fraud Warning Certification statement located on the reverse side of this form. I also authorize any physician / hospital that has attended me or my dependent child to disclose information acquired for claim payment purposes.

Printed Name Parent/Guardian or Adult Claimant _____

Signature of Parent/Guardian or Adult Claimant _____ Date _____

Signature - Please read the statement that applies to your state of residence and sign the bottom of the page.

With the exception of any source(s) of income reported above in this form, I certify by my signature that I have not received and am not eligible to receive any source of income, except for my disability benefits from this plan. Further, I understand that should I receive income of any kind or perform work of any kind during any period The Hartford has approved my disability claim, I must report all details to The Hartford, immediately. If I receive disability income benefits greater than those which should have been paid, I understand that I will be required to provide a lump sum repayment to the Plan. The Hartford has the option to reduce or eliminate future disability payments in order to recover any overpayment balance that is not reimbursed.

For residents of all states EXCEPT Arizona, California, Colorado, Florida, Kentucky, Maine, Maryland, New Jersey, New York, Oregon, Pennsylvania, Puerto Rico, Tennessee, Virginia and Washington: 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.

For Residents of 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.

For Residents of 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.

For residents of 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 award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

For residents of Florida: 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.

For residents of Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim or an application for insurance 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.

For residents of Maine, Tennessee, Virginia and Washington: 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 and denial of insurance benefits.

For Residents of Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit and who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For residents of New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. Any person who includes any false or misleading information on an application for insurance policy is subject to criminal and civil penalties.

For residents of New York: 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.

For residents of Oregon: 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 that the insurer relied upon is subject to a denial and/or reduction in insurance benefits and may be subject to any civil penalties available.

For residents of 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 hereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

For residents of Puerto Rico: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

The statements contained in this form are true and complete to the best of my knowledge and belief.

_____ _____

Signature of Policyholder Official Date

_____ _____

Signature of Parent/Guardian or Adult Claimant Date

Electronic Funds Transfer (EFT) is our standard method of payment. When making our claim decision we may contact you to obtain your banking information.