CORTLAND ENLARGED CITY SCHOOL DISTRICT

1 Valley View Drive
Cortland, New York 13045

Kimberly Vile
Director of Business Services
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Business Office
(607) 758-4100
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To: CECSD Parents
From: Kimberly Vile
Regarding: Student Accident Forms
Date: July 19, 2016

I am sorry that your child has been injured. Effective July 1, 2016 we will no longer be submitting Student Accident forms to Pupil Benefits. The new carrier, Commercial Travelers has a different form that is attached. This accident claim form needs to be completed for any student sustaining an injury during school or at after school sports/activities.

The school personnel, typically the nurse will complete Part A of the form that includes a section designating how/where the injury occurs. The district is asking that the nurse sign as the "Signature of School Official/Title" and then have the Principal initial on the same line prior to forwarding a copy of this document to Ken Waldby, Safety Officer to review the incident and strategize ways to reduce future injuries.

Part B of the form needs to be completed by you as the parent/guardian. Remember this is secondary to insurance coverage you have on your child. The business office will assist you in any way possible however you have the information that is required on page 2 of the form. After the form is completed with your personal information and supporting documentation please send to:

Commercial Travelers Mutual Insurance Company
Commercial Travelers Building
Utica, New York 13502

If you have any questions please contact either the school nurse or Andie Davis, Senior Account Clerk at the district office, 607-758-4100 extension 2206. The carrier will contact either the district or you regarding claim processing.

Plan Administered by:

COMMERCIAL TRAVELERS MUTUAL INSURANCE COMPANY
COMMERCIAL TRAVELERS BUILDING
UTICA, NEW YORK 13502

For Toll-free Policyholder Service 1-800-756-3702 • Utica area 315-797-5200

Please check the correct Underwriting Company:

☑ COMMERCIAL TRAVELERS MUTUAL INSURANCE COMPANY
☐ NIAGARA LIFE AND HEALTH

Notice: When we are the secondary plan, we do not pay until after the primary plan has paid its benefits if any. We will review Usual & Customary charges of each plan and allow the highest. Any amount paid by your primary plan for an eligible expense under our plan may satisfy all or a portion of our deductible.

CLICK HERE TO RESET FORM

EmblemHealth GHI network access
www.emblemhealth.com
1-866-861-7153

Instructions
1. PART A — must be completed by a school official.
2. PART B — must be completed by Parent or Guardian
3. Contact all medical care providers and request that they bill us as the secondary insurance. If they will not bill us directly:
   a. Include copies of itemized bills that include a diagnosis.
   b. Include copies of Explanation of Benefits statements from your Primary insurance carrier—one for each bill.
   c. Later itemized bills and Explanation of Benefit statements can be mailed separately. Make sure the name of the student is on all correspondence.
4. Save copies of submitted materials for your records.

Accident Claim Form

Please print or type

Part A: School Report

Instructions — school official completes this Part A, then gives the form to the student's parent or guardian to complete Part B on the reverse side. **Parent must provide name of school/school district, if not school related accident.**

If you have submitted an accident report to another insurance company, please attach a copy.

Name of School

Phone No.

School District/Policyholder

Cortland Enlarged City School District

Address

Street/Box# City State Zip

Policy No.

Name of Student

☐ Male ☐ Female

Grade

Date of Accident

Time of Accident
☐ AM
☐ PM

How Accident Occurred
☐ Enroute to/from school
☐ During school session
☐ Practice or play of interscholastic sports
Name of Sport _____ ☐ JV ☐ Varsity
☐ Other _____

How did accident happen?

Details of Injury — including part of body injured:

Name of Teacher or Coach Supervising the Activity

Any person who knowingly and with intent to defraud any insurance company or other person files an application for health insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, any 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 $5,000.00 and the stated value of the claim for each such violation.

Signature of School Official/Title

Date Signed

—Reverse side must be completed by parent or guardian—

Accident Claim Form
Please print or type

Part B: Statement of Parent or Guardian

Name of Injured Student	Social Security No.	Date of Birth / /	Date of Accident / /

Name of Person Making this Report | Relationship to Student

Address
Street/Box# City State Zip

Telephone
Home ( )
Work ( )

Name of Student's **Male Parent** or Guardian | Occupation | Social Security No.

Address if different from student

Employer's Name and Address

Name Street/Box# City State Zip Phone #

Name of Student's **Female Parent** or Guardian | Occupation | Social Security No.

Address if different from student

Employer's Name and Address

Name Street/Box# City State Zip Phone #

Does either parent or guardian have Accident/Health Insurance which covers this student? ❒ Yes ❒ No
If yes, which person(s)

Name of Insurance Company(ies) | Name of Policyholder(s)

For Around-the-Clock Coverage only:

Date of injury (or) onset of sickness _____ When was physician first consulted? _____

Nature of injury (or) illness _____

If injury, how and where did accident occur? _____

Have you suffered same or similar condition in the past? ❒ Yes ❒ No If "Yes,' and if you were treated for, it, please give name and address of the physician who treated you _____

Dates treated _____

Give name, address and telephone number of usual family physician _____

_____ Phone _____

I hereby authorize any physician, hospital, company, employer, or organization to release any information regarding the medical history, treatment, or benefits payable for this claim, to the Insurance Company checked on the reverse or its authorized benefit plan administrator. A photostatic copy of this authorization shall be as valid as the original.

I also authorize the Insurance Company checked on the reverse or their representatives to pay all bills in connection with this claim directly to the doctor, hospital or any other persons rendering service, and such payment shall release the Insurance Company from liability as to amounts so paid.

I hereby certify that I have read the answers to all parts of this form and to the best of my knowledge and belief the information is complete and correct as given herein.

Name of Student _____

Any person who knowingly and with intent to defraud any insurance company or other person files an application for health insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, any 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 $5,000.00 and the stated value of the claim for each such violation.

Signature of Parent or Guardian	Date Signed