

STUDENT ACCIDENT CLAIM FORM

Please follow the time frames listed below and submit to the ISDA Claims Administrator by the required due dates.

- 1. Claim Form must be submitted no later than 90 days after the date of injury,**
- 2. Itemized bills must be submitted no later than 180 days after the date of treatment, and**
- 3. Explanation of Benefits (EOB) must be submitted no later than 180 days after the date of treatment.**

Items #1, #2, and #3 must be submitted to the ISDA Claims Administrator if the Parent or Guardian has other insurance

INSTRUCTIONS

PLEASE RETAIN A COPY FOR YOUR FILES

1. The Insured's School must complete the application.
2. In case of dental injury, the treating dentist must complete the Student Accident Dental Services Form (below).

NOTICE OF INJURY FROM SCHOOL (Please PRINT)

Name of School and School District _____

Address of the School District (including city, state, and zip code) _____

Name of School Official Reporting Injury _____ School Contact Phone _____

Email Address of School Official _____

Name of Student _____ Student Date of Birth _____

Grade of Student _____

Name of Person supervising activity _____

Name of additional witness if any _____ Date of Injury _____ Time _____ AM/PM

The injury occurred while the student was participating in: (please CHECK ANY THAT APPLIES)

INTERSCHOLASTIC SPORTS Name of Sport _____ Game _____ Practice _____

ACTIVITY Travel to/from School _____ Recess _____ Physical Education _____ Classroom _____ School Grounds _____ Other _____

Please specify Other Activity _____

Part of the body injured _____ Right/Left side _____

Describe how injury happened (Please BE SPECIFIC):

Name of Parent or Guardian _____ Parent or Guardian Contact Phone _____

Parent or Guardian Email Address _____

Home Address (including city, state, and zip code) _____

Signature of School Official _____ Title _____ Date _____

STUDENT ACCIDENT DENTAL SERVICES FORM

TO BE FILLED OUT BY THE TREATING DENTIST

Date of Injury _____ If a Prosthesis is required, is this an initial placement? _____

Was the tooth/teeth sound prior to the current treatment? YES/NO _____

NAME OF DENTAL INSURANCE PLAN _____

TOOTH NO.	DESCRIPTION OF SERVICE	DATE OF SERVICE	FEE
			TOTAL FEE

Print Dentist's Name

Dentist's Signature

Street Address

City State Zip

Date

FEDERAL TAX ID NUMBER (REQUIRED FOR PROCESSING)