The Foursquare Church

ACTIVITIES INSURANCE CLAIMS KIT INSTRUCTIONS
FOR LOCAL CHURCH, SCHOOL, OR CAMP

To process claims in a timely manner, please follow these instructions in detail for injuries that occurred at an event sponsored by a local church, school, or camp.

DO NOT USE THIS CLAIM KIT TO REPORT INJURIES INCURRED BY LOCAL CHURCH OR SCHOOL EMPLOYEES.

The Activity Policy is a secondary, or excess medical insurance policy for accident related injuries. This means that it will pay after his or her own health plan pays. This policy may pay remaining balances up to the policy limits. However, if the injured party does not have health insurance, our policy will reimburse eligible medical payments made by the claimant. *Some exclusions may apply or will be based on approval. In either case, a $250 deductible may apply, however, this deductible will be the responsibility of the injured party.

Should you have a death, dismemberment and/or paralysis claim, please call the Foursquare Claims Administrator at 213-989-4403 immediately. There is additional information that will be needed to process this type of claim. The Claims Administrator will then advise Foursquare Corporate Counsel of such claims and give advance notice to AIG Insurance should a lawsuit be filed with regards to the injury.

General Instructions:

- When completing form(s), print clearly in block letters using blue ink.
- Fill in every blank. If the question does not apply to your claim, write "N/A" in the box. This will let the adjuster know that you did not overlook the question.

Instruction for completing the AIG Special Risk Accident & Sickness Claim Form

TO BE COMPLETED BY CHURCH/SCHOOL/CAMP

SECTION A

Complete all of "Section A" in detail. This section is mandatory for filing a claim. This section establishes the date of loss, validates coverage and collects any information needed, including details regarding pre-existing medical treatment and treating physicians.

1) Provide the legal name and code number of the local church, school, or camp.
2) Include the claimant's social security number.
3) The policy renews annually March 1st. The policy information should read: 3/1/16 to 3/1/17.
4) Complete all sections including a brief description of the incident.
5) The Pastor or other authorized staff member must sign the claim form before giving it to the injured party or legal guardian of the injured party.

HIPAA

The HIPAA rule provides federal protections for personal health information. The injured person or legal guardian is responsible to read and sign the HIPAA form to expedite the handling of the claim.

Note: Once you have given the claim form to the injured person or guardian, your office can no longer handle this claim due to the HIPAA laws. It is the responsibility of the injured party to complete the claim forms and submit them to the insurance company or claims office. All further correspondence and calls should be between the injured person and the claims adjuster.

TO BE COMPLETED BY THE INJURED PERSON OR LEGAL GUARDIAN

Please be advised that the Activity Insurance Policy is secondary (pays after his or her own health plan's payment), or excess, to your personal health insurance. This policy may pay remaining balances up to the policy limits. If the injured party does not have health insurance, our policy will reimburse eligible medical payments made by the claimant. (Some exclusions may apply or will be based on approval.)

The injured person is responsible for a $250 deductible per claim (if you do not have primary insurance). If you have primary insurance, AIG will waive the deductible. When the carrier adjusts the claim, this amount is automatically deducted from the claim payments. The adjuster will send the injured person an Explanation of Benefits (EOB) outlining what has been paid.

If the deductible is applied by AIG, the injured party would write a check to the doctor, hospital or provider for the $250 deductible amount.

SECTION B

Complete "Section B" in detail. This section is mandatory for filing a claim. The injured party or guardian must provide the medical insurance information. If the person does not carry medical insurance, he/she must write "N/A" to indicate that this information has not been overlooked.

1) Your primary medical/health insurance company's information; if you have no other insurance coverage, please write "N/A" in this section.
2) If the claimant is a minor, include the legal guardian's information: name, relationship to the claimant, and address.
3) Your employers' address and contact information. If a minor, include the legal guardian's employer.
4) Please read the "Assignment of Benefits" section on the claim form and check the appropriate box. This section allows you to authorize payment of policy benefits directly to a medical provider. **Your signature is needed at the bottom of the form.**

HIPAA

For those who have personal health insurance, our program is secondary and some hospitals, doctors' offices, and/or treating facilities cannot release any information to our claims adjusting company. This form authorizes the provider to give medical and treatment information to a third party.

Please read the attached information sheet; it is very important regarding privacy and HIPAA. The HIPAA rule provides federal protections for personal health information. The injured person or legal guardian is responsible to read and sign the HIPAA form to expedite the handling of the claim

REPORTING THE CLAIM

1) Once the injured party or legal guardian has completed and signed the forms, ONLY ask for copy of the first page and the HIPAA form.

2) Submit the completed **original claim form** with the **HIPAA form** to the following address:

AIG Claims Insurance
Accident & Health Claims Department
P.O. Box 25987
Shawnee Mission, KS 66225-5987
Fax: 866-893-8574
Email: aandh.claimssubmissions@aig.com

3) Mail, fax or email a **copy of both the claim form and HIPAA form** to Foursquare Insurance Services for our records to: Claims– Attn: Bridget Ellis, P.O. Box 26902, Los Angeles, CA 90026-0176, Fax: 213-989-4531, Email: bellis@foursquare.org

4) **Keep a copy** in your files.

WHAT IS NEEDED TO PROCESS A CLAIM

In order for a claim to be processed, the injured party is responsible to advise all providers to submit documents to AIG for review and processing of payments.

This would include submission of:

1) Receipts;
2) An itemized bill for services rendered showing name of claimant, dates of service, description and charge of each service, and nature of injury/diagnosis (note: **The procedure/diagnosis code is required** and provided by your health care provider). A second bill or past due notice does not typically contain this information and may not substituted;
3) Itemized insurance billing forms such as CMS/HCFA 1500 form for physicians; UB92 form for facilities; and
4) Explanation of Benefits (EOB) statement from the primary insurance carrier.

The church should never pay any bills upfront. If the deductible is applied by AIG, the injured party would write a check to the doctor, hospital or provider for the $250 deductible amount.

AIG
Accident and Health Claims Department
PO Box 25987
Shawnee Mission, KS 66225 (800) 551-0824
Telephone (866) 893-8574 Facsimile

REQUEST FOR PROTECTED HEALTH INFORMATION

Client Name:	
A&H Member Name/ Location Number:	
Policy Number:	SRG0009104952B
Date(s) of Service:	

Request By:	❒ Client
	❒ Legally Authorized Representative
	❒ Other
	Name:
	Relationship to Client:
	Contact Information
	❒ Mailing Address:
	City: | State:
	❒Telephone: ( ) - | ❒Fax: ( ) -
	❒E-Mail:

Purpose(s)	❒ Claim Status
	❒ Amendment (Specify in writing on a separate sheet)
	❒ Other (Specify in writing on separate sheet)

Information Required:	❒ Claim Status
	❒ Diagnosis
	❒Other/Specify:

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected under federal law.

I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance upon this authorization. If I revoke my authorization, the information described above may no longer be used or disclosed for the purposes described in this authorization. Unless revoked earlier, this authorization will expire 180 days from the date of signing or on _____.

_____ _____
Signature of Client or Client's Legally Authorized Representative Date

_____ _____
Print Clients Names or Name of Legally Authorized Representative Relationship to Client

_____ _____
Signature of Requesting Individual Date

_____ _____
Print Name of Requesting Individual Relationship to Client

This Form must be signed by the Client or Client's Legally Authorized Representative and the Requesting Individual. Please fax this completed form to: 866-893-8574.

AIG
A&H Claims Department
P.O. Box 25987
Shawnee Mission, KS 66225-5987
800-551-0824

The Foursquare Church

PROOF OF LOSS NAME OF GROUP:
International Church of the Foursquare Gospel
POLICY NUMBER: SRG0009104952B

SPECIAL RISK ACCIDENT AND SICKNESS CLAIM FORM

INSTRUCTIONS

1) You must have SECTION A fully completed by a designated official of the Policyholder.
2) SECTION B is to be completed, signed and dated by the claimant or parent/guardian of claimant, if claimant is a minor.
3) Attach itemized bills for all medical expenses being claimed including the claimant's name, condition being treated (diagnosis), description of services, date of service(s) and the charge made for each service. PLEASE MAIL COMPLETED FORM AND BILL TO ABOVE ADDRESS.

☐ PRIMARY PLAN – benefits are payable for covered medical expenses from the first dollar without regard to payments made by other insurance up to the policy maximum	☐ EXCESS PLAN – Eligible covered expenses will be determined after benefits have been paid by other valid and collectible insurance. You must submit your claim to your other insurance company first. When you receive their Benefit Statement (EOB) send it to us along with the itemized bills. Benefits for eligible expenses will be paid per policy terms.

The furnishing of this form, or it acceptance by the Company, must be construed as an admission of any liability on the Company, nor a waiver of any of the conditions of the insurance contract.

SECTION A – MUST BE COMPLETED AND SIGNED BY A DESIGNATED REPRESNTATIVE OF THE POLICYHOLDER

NAME AND LOCATION OF CHURCH/SCHOOL, ETC.

CLAIMAINT'S FULL NAME (PLEASE PRINT CLEARLY OR TYPE) SOCIAL SECURITY NO. MANDATORY DATE OF BIRTH CLAIMAINT PHONE NO.

DATE COVERAGE BEGAN DATE COVERAGE WILL END/HAS ENDED

NATURE OF INJURY OR ILLNESS (DESCRIBE FULLY, INCLUDING WHICH PART OF BODY WAS INJURED)	DESCRIBE HOW, WHEN AND WHERE ACCIDENT OCCURRED (DATE AND TIME)
NAME OF ACTIVITY	DID ACCIDENT OCCUR: A. WHILE CLAIMANT WAS SUPERVISED ☐ YES ☐ NO B. DURING SPONSORED ACTIVITY ☐ YES ☐ NO C. DURING PROGRAMMED HOURS ☐ YES ☐ NO D. WHILE TRAVELING TO OR FROM REGULARLY SCHEDULED ACTIVITY IN A SUPERVISED GROUP ☐ YES ☐ NO
INDICATE THE SPORT (IF APPLICABLE)	

DATE LAST WORKED	DATE RETURNED TO WORK	WEEKLY EARNINGS
POLICYHOLDER REPRESENTATIVE (PLEASE PRINT OR TITLE TYPE)	DAYTIME TELEPHONE NUMBER ( )	
SIGNATURE OF POLICYHOLDER REPRESENTATIVE	DATE	NAME OF SUPERVISOR

SECTION B- MUST BE COMPLETED

LIST NAME, ADDRESS, AND PHONE # OF OTHER INSURANCE COMPANIES UNDER WHICH CLAIMANT IS INSURED: POLICY #/ACCOUNT #

IF CLAIMANT IS A MINOR, NAME OF CLAIMANT'S GUARDIAN/RELATIONSHIP TO CLAIMANT

ADDRES OF CLAIMANT (IF CLAIMANT IS A MINOR, NAME AND ADDRESS OF CLAIMANT'S GUARDIAN)	CLAIMANT'S SOCIAL SECURITY NUMBER
NAME/ADDRESS/TELEPHONE # OF EMPLOYER (IF CLAIMNAT IS A MINOR, GUARDIAN'S EMPLOYER	EMPLOYER'S DAYTIME TELEPHONE # ( )

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF

AUTHORIZATION and ASSINGMENT OF BENEFITS

I, the undersigned authorize any hospital or other medical-care institution, physician or other medical professional, pharmacy, insurance support organization, governmental agency, group policyholder, insurance company, association, employer or benefit plan administrator to furnish to the Insurance Company named above or its representatives, any and all information with respect to any injury or sickness suffered by, the medical history of, or any consultation, prescription or treatment provided to, the person whose death, injury, sickness or loss is the basis of claim and copies of all of that person's hospital or medical records, including information relating to mental illness and use of drugs and alcohol, to determine eligibility for benefit payments under the Policy Number identified above. I authorize the group policyholder, employer or benefit plan administrator to provide the Insurance Company named above with financial and employment-related information. I understand that this authorization is valid for the term of coverage of the Policy identified above and that a copy of this authorization shall be considered as valid as the original. I understand that I or my authorized representative may request a copy of this authorization.

I authorize payment of medical benefits to the physician or supplier for service performed. ☐ YES ☐ NO

CLAIMAINT OR AUTHORIZED PERSON'S SIGNATURE DATE

SRG_ASGN/REV 1.0, 8/2002