



BOY SCOUTS OF AMERICA

- 1. PLEASE FULLY COMPLETE THIS FORM
- 2. ATTACH ITEMIZED BILLS WITH DOCTOR'S DIAGNOSIS
- 3. MAIL TO HEALTH SPECIAL RISK, INC.

HSR
Health Special Risk, Inc.

HSR Plaza
4001 North Josey Lane
Carrollton, TX 75007-1520
866-726-8870
Fax 972-492-4946

To be completed by BSA Leader

Council Name: Northern Star Council
Address: 393 Marshall Avenue
St. Paul, MN 55102
Telephone Number: 651-224-1891
Policy PTP N00327402

PART 1 - BSA Leader's Statement

Check One: Tiger Cub Tiger Cub Adult Varsity Scout Learning for Life - Explorer Learning for Life - Non-Explorer
 Cub Scout Venturer Leader Committee Seasonal Staff Other _____
 Check Policy: Council Unit Learning for Life Campers & Special Events National Events

Post Number _____ Team Number _____ Troop Number _____ Pack Number _____

1. Name of Insured (Claimant) _____ 2. Social Security Number _____ 3. Sex F M 4. Birthday ___/___/___

5. Address of Insured
Street _____ City _____ State _____ Zip _____

6. Parent's name, address and telephone number (include area code) _____

7. What date did accident happen or sickness begin? _____ 8. Nature of injury or sickness (indicate part of body injured - such as broken arm, sprained ankle, etc.) _____

9. Describe how accident occurred - give details _____

FOR DENTAL CLAIMS ONLY 10. Indicate which teeth were involved in the accident _____ 11. Describe condition of injured teeth prior to accident:
 Whole, sound and natural Filled Gapped Artificial

12. Name of event or activity _____ 13. Name and title of supervisor _____

14. Signature of policyholder representative X _____ 15. Title _____ 16. Date _____

PART 2 - Other Insurance Statement

Do you/spouse/parent have medical/health care coverage through your employer or other source on you? YES NO
 If Yes, name of insurance company _____ Policy # _____

Is the Claimant enrolled as an individual, employee or dependent member of one of the following:
 Preferred Provider Organization (PPO), Health Maintenance Organization (HMO) or similar prepaid health care plan, or any other type of accident/health/sickness plan? YES NO
 If Yes, name of insurance company _____ Policy # _____

If your son/daughter has health care coverage as a dependent from your previous marriage as mandated in a divorce decree, please provide the following:
 Name of Insurance Company _____ Policy # _____

IF OTHER INSURANCE OR HEALTH CARE PLANS EXIST, PLEASE SUBMIT COPIES OF THEIR EXPLANATION OF BENEFITS ALONG WITH YOUR CLAIM.

IF NO OTHER INSURANCE or HEALTH PLAN EXISTS, PLEASE READ & SIGN BELOW.
 I agree that should it be determined at a later date there is insurance (or similar), to reimburse HEALTH SPECIAL RISK, INC., or the insurance company to the extent of any amount collectible.

Signature of participant or parent X _____ Witness _____ Date _____

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

Authorization to pay benefits to provider
 I authorize medical payments to physician or supplier for services described on any attached statements enclosed.
 Signature X _____ DATE _____

Authorization for release of information
 hereby authorize any insurance company, hospital, physician or other person who has attended or examined the claimant to disclose when requested to do so, all information with respect to any injury, policy coverage, medical history, consultation, prescription or treatment, and copies of all hospital or medical records. A photostatic copy of this authorization shall be considered as effective and valid as the original.
 Signature X _____ DATE _____

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