HSR
Health Special Risk, Inc.

P.O. Box 117558
Carrollton, Texas 75011-7558
Phone: (972) 512-5600 Fax: (972) 512-5818
Toll Free (866) 243-7885

School District: _____

City and State: _____

School Name: _____

Policy Number: _____

STUDENT CLAIM FORM

1. Please fully complete this form
2. Attach itemized bills
3. Mail to *HSR*

* *DENOTES REQUIRED INFORMATION*

PART I – POLICYHOLDER'S REPORT

1.* Claimant's Name (injured/ill person)	2.* Social Security Number	3.* Gender ☐M ☐F	4.* Date of Birth	5. E-Mail
6.* Address of Injured Person	* City	* State	* Zip	7. Phone Number
8.* Parent's Name & Address	* City	* State	* Zip	9. Parent's Phone Number

10.* Date of Accident/Illness	11. Time of Accident ☐a.m. ☐p.m.	12.* Place where Accident Occurred	13.* Date of First Treatment

Dental Claims	14.* Indicate which Teeth were Involved in the Accident	15.* Describe Condition of Injured Teeth Prior to Accident: ☐ Whole, Sound, and Natural ☐ Filled ☐ Capped ☐ Artificial

16.* Type of Injury (Indicate Part of Body Injured – e.g. broken arm, sprained ankle, etc.) Did Injury Result in Death? ☐Yes ☐No

17.* Describe How Accident Occurred or the Nature of the Illness – Give all possible details

18.* Which Best Describes the Activity:

☐ Play or practice of interscholastic sports	☐ During lunch hour	☐ Athletic period
☐ Not school related	☐ In school bus	☐ On school property during school hours
☐ P.E. class	☐ School sponsored field trip	☐ School sponsored activity during school hours
	☐ Traveling to/from school	☐ A spectator

19.* Name of Person Supervising the Activity

20.* If engaged in an Interscholastic Sport at the time of the injury, what was the sport?

* Signature of Parent/Legal Guardian:		* Signature of School Official:	
X	Date:	X	Date:

* PART II – OTHER INSURANCE STATEMENT

Do you/spouse/parent have medical/health care or is the Claimant enrolled as an individual, employee or dependent member of a Health Maintenance Organization (HMO) or similar prepaid health care plan, or any other type of accident/health/sickness plan coverage through your employer or other source on you or, if applicable, does your son/daughter have health care coverage as a dependent from your previous marriage as mandated in a divorce decree? ☐ Yes ☐ No

If Yes, name of insurance company _____ Policy # _____

Name of insurance company _____ Policy # _____

If applicable, claimant's primary employer name, address, and phone number _____

If applicable, mother's primary employer name, address, and phone number _____

If applicable, father's primary employer name, address, and phone number _____

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 Parent/Legal Guardian:		Signature of Witness:	
X	Date:	X	Date:

* PART III – AUTHORIZATION TO PAY BENEFITS TO PROVIDER

I hereby authorize medical payments to be made directly to doctor(s), hospital(s), or indicated provider(s) of service(s) in connection with this claim.

(Otherwise submit proof of payment)

SIGNATURE _____ DATE _____

I 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 photo static copy of this authorization shall be considered as effective and valid as the original.

SIGNATURE _____ DATE _____