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.
E-Mail: boyscouts@hsri.com

HSR
Health Special Risk, Inc.

HSR Plaza
4100 Medical Parkway
Carrollton, TX 75007-1517
Toll Free 866-726-8870
Fax 972-512-5820

To be completed by BSA Leader
Council Name: _____
Address: _____
_____
Telephone Number: _____
☐ Youth ☐ Youth & Adult ☐ LFL ☐ Family

PART 1 - BSA Council Representative Statement

Check One: ☐ Tiger Cub ☐ Tiger Cub Adult ☐ Cub ☐ Scout ☐ Venturer ☐ Varsity Scout ☐ Leader ☐ Explorer
☐ Learning for Life – Curriculum Based ☐ Volunteer Seasonal Staff ☐ Committee ☐ Family Member

Check Policy: ☐ Council ☐ Unit ☐ Campers & Special Events ☐ National Events

Check One: Are you a member of or is your unit sponsored by the Church of Latter Day Saints? ☐ Yes ☐ No Any participant in an LDS sponsored unit is ineligible for coverage under this policy because their church has already provided insurance through another company Deseret Mutual (1-800-777-3622).

Pack, Troop, Post, Team or Crew #	1. Claimant's Name (Injured/Sick Person)	2. Social Security Number - -	3. Gender ☐ M ☐ F	4. Birthday / /

5. Claimant's Address (Street, City, State, Zip Code) and best contact telephone number (include area code)

6. If applicable, parent or legal guardian's name, address and best contact telephone number (include area code)	7. E-Mail

8. What date did accident happen or sickness begin?	9. Nature of injury or sickness (indicate part of body injured – such as broken arm, sprained ankle, etc.)

10. Describe how accident occurred – give details Did Injury Result in Death? ☐YES ☐NO

11. Name of event or activity	12. Name and title of adult leader

13. **Signature of Council representative** X	14. Title	15. Date

PART 2 – 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 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 second insurance company _____ Policy #_____

Coverage is Excess of All Other Insurance or Healthcare plans in Force

This policy is excess to any and all other available source of medical insurance or other healthcare benefits. You must file your bills through your primary/personal insurance carrier or healthcare plan prior to this policy responding. When your primary insurance company or healthcare plan processes the charges, they will send you an Explanation of Benefits, or "EOB." Please submit copies of their Explanation of Benefits along with your claim to Health Special Risk, Inc. In the event you have no other primary insurance or healthcare plan, this policy with pay as primary subject to the plan limits and terms.

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, parent or legal guardian X	Date

NOTE: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose or misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Authorization to pay benefits to provider

I authorize medical payments to physician or supplier for services described on any attached statements enclosed. (If not signed submit proof of payment)

Signature X_____ **DATE** _____

Authorization for release of information

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 photostatic copy of this authorization shall be considered as effective and valid as the original.

Signature X_____ **DATE** _____

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