CLAIM FORM
ORIGINAL SIGNED CLAIM FORM IS REQUIRED

SENTRY® LIFE INSURANCE COMPANY

MAIL ALL CORRESPONDENCE TO:
Stevens Point Policy Benefits
P.O. Box 8025
Stevens Point, WI 54481
1-800-426-7234 Toll-Free

IMPORTANT NOTICE
Your student insurance plan is designed to provide maximum benefits for minimum premium. This plan of insurance is secondary to any health insurance you have. If you have other insurance, submit your claim to your other insurer. When you receive their Benefit Statement, send it to us along with your itemized bills, with diagnosis, and this completed form. **SEE REVERSE SIDE FOR ADDITIONAL INSTRUCTIONS ON FILING A CLAIM**

TO BE COMPLETED BY THE ORGANIZATION/SCHOOL

Policy Number:_____

Organization/School Name:_____

Address:_____ Phone No. (___) _____

_____ Type of Activity: _____

If Athletics, designate: ☐ P.E. Class ☐ Intramural ☐ Interscholastic ☐ Practice ☐ Game ☐ Jr. Varsity ☐ Varsity

At the time of Injury, was the student involved in a school sponsored and supervised activity? Yes ☐ No ☐

Under whose supervision?_____ Was he/she a witness? ☐ Yes ☐ No

Date of Accident: _____ Time: _____

Where & How did Accident occur? (Please be specific) _____

_____

_____

Part of body injured: _____ Date of first treatment: _____

Signature: X _____ **Title:**_____ **Date:** _____

(MUST BE SIGNED BY AN ORGANIZATION/SCHOOL OFFICIAL UNLESS INJURY DID NOT OCCUR DURING ORGANIZATION/SCHOOL ACTIVITY. ORIGINAL SIGNATURE IS REQUIRED.)

TO BE COMPLETED BY CLAIMANT – OR BY PARENT/LEGAL GUARDIAN IF CLAIMANT IS A MINOR

Claimants Name:_____

Date of Birth:_____ Age:_____ Grade Level:_____ ☐ Male ☐ Female

Address of Parents
Guardian or Claimant:_____

_____ Phone No. (___) _____

Name and address of Family Physician: _____

_____

Phone No. (_____) _____ Has treatment been completed? ☐ Yes ☐ No

Father/Guardian Name: _____

Employer Name & Address: _____

_____ Phone No. (___) _____

Mother/Guardian Name: _____

Employer Name & Address: _____

_____ Phone No. (___) _____

PLEASE CONTINUE TO BACK OF THE FORM WHICH MUST BE COMPLETED

Name of all companies providing your insurance coverage or prepaid health plans:

Name of Company **Address** **Policy #**

PLEASE CHECK BOX

☐ Individual ☐ Group
☐ Self-Funded ☐ No Insurance
☐ Other (Any Valid & Collectible Insurance)

Are benefits due for this claim under these other insurance coverages? ☐ Yes ☐ No

(See IMPORTANT NOTICE at top of form reverse side)

I verify that the above statement on other insurance is accurate and complete. I understand that the intentional furnishing of incorrect information via the U.S. Mail may be fraudulent and violate federal laws as well as state laws. I agree that if it is determined at a later date that there are other insurance benefits collectible on this claim I will reimburse Sentry Life Insurance Company to the extent for which Sentry Life Insurance Company would not have been liable.

Signature: _____ **Date:** _____

ORIGINAL SIGNATURE IS REQUIRED

OPTIONAL AUTHORIZATION TO RELEASE INFORMATION:

I hereby authorize Sentry Insurance to discuss any information related to medical expenses incurred or treatments rendered in connection with this claim, with Special Markets Insurance Consultants, Inc. representatives and their assigned agents and to officials at the school or organization through which this policy is issued. A photo static copy of this authorization shall be considered as effective and valid as the original.

Signature: _____ **Date:** _____

Claimant if age 18 or over, parent or guardian for claimant under 18

SEVERAL STATES REQUIRE THE FOLLOWING STATEMENT TO APPEAR ON THIS FORM:

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES A STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS INFORMATION CONCERNING ANY MATERIAL FACT FOR THE PURPOSE OF MISLEADING, COULD BE GUILTY OF INSURANCE FRAUD WHICH MAY BE A CRIME. THIS DOES NOT APPLY TO VIRGINIA RESIDENTS.

OKLAHOMA: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY.

PLEASE FOLLOW THESE INSTRUCTIONS TO FILE A CLAIM

- Obtain claim form from your school office or the marketing agent and answer all questions in detail (including all signatures on the front of the form). A claim form needs to be completed for each accident.
- If you have other insurance, submit your claim to your other insurer. When you receive the **EXPLANATION OF BENEFITS NOTICE FROM YOUR PRIMARY CARRIER**, send it to us along with the corresponding **ITEMIZED BILLS** with diagnosis along with this fully completed claim form. **KEEP COPIES OF ALL CLAIM FORMS, BILLS AND CORRESPONDENCE FOR YOUR OWN RECORDS UNTIL YOUR CLAIM HAS BEEN PROCESSED.**
- If you already paid the bill, include a paid receipt or a copy of your cancelled check. Otherwise payment will be made to the providers of service (Hospital, Physician or Others), unless a paid receipt statement accompanies the bill at the time the claim is submitted.
- Mail all correspondence to Stevens Point Policy Benefits, P.O. Box 8025, Stevens Point, WI 54481. The claim form must be sent within 90 days of the date you first received medical care. Any bills not filed with the claim form should be sent, within 90 days of the date you received medical care, to the Company identified with student's name, school district and date of Accident.
- If you change your address, please notify Sentry Life Insurance Company by calling 1-800-426-7234 so that there is no delay in processing any claims.
- Please contact Sentry Life Insurance Company by calling 1-800-426-7234 if you would like to check the status of your claim or if you have any questions on how your claim was processed or the benefit paid.