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Educational & Institutional Insurance Administrators, Inc. (EIIA)

Participating Higher Education Institution Claim Form

IMPORTANT INSTRUCTIONS FOR COMPLETING CLAIM FORM(S)

To the Policyholder and Claimant:

As we know this is a difficult time, we want to assist you in filing your claim as quickly as possible. Please read the important instructions below regarding completing these claim form(s) in their entirety and accurately.

The information below constitutes a complete claim filed with Everest for purposes of claiming Personal Accident Benefits, Medical Expense Benefits and/or Travel Inconvenience Benefits.

Instructions:

1. **Part 1 – Policyholder's Statement**, to be completed in its entirety and signed by the Official Representative of the Policyholder/Plan.
    a. Provide any necessary and/or required attachments (per Section D)
2. **Part 2 – Claimant's Statement**, to be completed in its entirety and signed by the Claimant for each occurrence and submitted to Everest.
    a. Provide all required documents including, but not limited to, Trip Details, Medical Reports, Receipts, and Bills, Details of the Accident or Incident, Purchase Receipts, Replacement Quotes and Police Reports.
    b. Please read the applicable Fraud Statement for your state of residence.
3. Submit **claim form, itemized medical bill(s)** and **supporting documentation** via mail or email (as provided below).

Helpful Information for submitting claims and expediting payment

- A fully-completed Notice of Claim is required for each accident/injury a Claimant incurs. Submitting incomplete information will delay the processing of your claim.
- Providers may wish to bill us directly for their services. If they do, please ensure a Notice of Claim has first been submitted to our office.
- Itemized medical bills (including claimant name, date(s) of service, diagnosis, procedure code(s), amount charged, and provider information) should be submitted for processing. Accordingly, we recommend providers submit standardized billing statements, specifically, UB-04 forms for hospital charges and/or CMS-1500 forms for physician charges.

Please detach this page and forward the completed Statement of Claim and supporting documentation to the address listed below. We recommend you retain copies of the items you have submitted for future reference.

Submit claim to: **Everest Re Group. Ltd.,**
Mailing Address: **Warren Corporate Center, 100 Everest Way, Warren, NJ 07059**
Phone: **908-635-8813 or 855-252-4695**
Email: **A&HClaims@everestglobal.com**

Release of claim forms is not an admission of coverage under a policy for a policyholder, group, or organization.

PLEASE ENSURE THAT ALL SECTIONS ARE FULLY COMPLETED AND SIGNED

Please check the appropriate benefit column for which you wish to make a claim:
To substantiate your claim, please ensure that all of the required documents outlined and stated below, along with the travel voucher, travel authorization, and air ticket are attached with this form. The company and insurance carrier may require further documentation as they deem necessary.

	Please ✓ the appropriate Benefit(s)		**Documents Required**
☐	Accidental Death	i) ii) iii) iv)	A **Certified Copy** of the final death certificate; Your company's enrollment benefits form and Beneficiary Designation; The Police Report and Autopsy Report; A copy of the Employee's itinerary prior to the accident, purpose of the trip, destination to and from the trip, and confirmation that trip was authorized by the company.
☐	Medical Expenses	i) ii)	Original Medical Report* with diagnosis/nature of injury from Hospital or duly certified by the attending physician or Treating Doctor; Original Medical Receipts and Bills. *Please provide if available
☐	Trip Delay/Interruption	i)	Written report from common carrier management indicating reason and the duration of such delay, interruption or cancellation.
☐	Trip Cancellation	i) ii)	Medical report by attending physician indicating your unfit to travel, or relevant death certificate; Official receipts of travelling and/or accommodation expenses incurred.
☐	Baggage Delay	i)	Written report from common carrier management indicating reason and the duration for baggage delay, misdirection or misplacement.
☐	Personal Property	i) ii) iii) iv)	Purchase receipts for lost items; Quotation of repairing damaged items; Complete Part 2 – Section G of this claim form; Official receipts for expenses incurred, such as replacement cost of luggage, passport or ticket.
☐	Personal Liability	i) ii) iii)	Details of accident Police report Other documents relating to this accident, if any

➔ PART 1 – POLICYHOLDER'S INFORMATION AND STATEMENT

A. Policyholder Information

Policy Number: **AHB0000013-241**
Policyholder Name: **Educational & Institutional Insurance Administrators, Inc. (EIIA)**
Participating Institution:
Participating Institution Address:
(Street, City, State, Zip Code)

B. Claimant Information

Claimant Name:
Claimant Date of Birth:
(Month / Day / Year)
Claimant Address:
(Street, City, State, Zip Code)
Relationship to Institution: Select Relationship
(Select from box; if other, explain below)
Claimant Phone Number:
Other Relationship:

C. Claim Information

Death and/or Medical Expense Benefits claimed due to: ☐ Accidental Death ☐ Accidental Injury ☐ Sickness

Trip Details (if applicable): Begin Date: (Month / Day / Year) Scheduled End Date: (Month / Day / Year)

Injury sustained/illness commenced during? ☐ Work Activity ☐ Personal Deviation ☐ Sponsored Trip

Has a Claim been filed for Workers Compensation? ☐ Yes** ☐ No

If **Yes, please provide Name of Carrier:
Address of Carrier:

For Claims due to Injury, please complete the following:

Date of Accident (Month / Day / Year):
Time of Accident: ☐ am ☐ pm

Nature of Injuries:
Place of Accident:

Full Description/Details of the Accident (attach additional notes if necessary):

For Claims due to Illness, please complete the following:

Date Illness first commenced (Month / Day / Year):

Full Description/Details of the Sickness (attach additional notes if necessary):

For Claims due to Travel Inconvenience, please complete the following:

Trip Details: Begin Date: (Month / Day / Year) Scheduled End Date: (Month / Day / Year)
Travelling From: Travelling to:
U.S. Travel: ☐ Yes ☐ No
Overseas Travel: ☐ Yes ☐ No
Mode of Transportation: ☐ Airline ☐ Train ☐ Boat/Ship

Travel Inconvenience Benefits claimed due to:

☐ Trip Delay/Interruption ☐ Trip Cancellation ☐ Baggage Delay ☐ Personal Property ☐ Personal Liability

Travel Inconvenience commenced while traveling for? ☐ Work ☐ Leisure

Full Description/Details of the Incident (attach additional notes if necessary):

_____

D. Required Documentation/Attachments and Signature

Please attach copies of the following documents as applicable:

- Medical information from the Claimant's file relating to this injury/illness, if available
- Company authorization and itinerary for Claimant's travel
- Incident/police reports relating to the incident
- Written report from common carrier management indicating reason and the duration of such delay, interruption or cancellation
- Written report from common carrier management indicating reason and the duration for baggage delay, misdirection or misplacement
- Purchase receipts for lost items
- Quotation for repairing damaged items
- Official receipts for additional travel expenses incurred
- Official receipts for expenses incurred, such as replacement cost of luggage, passport or ticket

CERTIFICATION

I hereby certify the Claimant is an Insured of the Policyholder under the above Policy and the loss was sustained under adequate supervision while participating in an official Covered Activity.

I certify that the information furnished by me on the Policyholder's Statement is true and correct and complete according to the records of the Policyholder. I agree that this information is subject to audit by Everest and/or its representatives.

Name of Authorized Policyholder Official:

Title of Authorized Policyholder Official:

Acknowledge your electronic acceptance by checking the box below:

☐ I understand that checking this box constitutes a legal signature confirming that I acknowledge and warrant the truthfulness of the information provided in this document.

Date (Month / Day / Year):

➔ PART 2 – CLAIMANT'S INFORMATION AND STATEMENT

A. Claimant Information

Name (Last, First, Middle Initial):

Date of Birth (Month / Day / Year): Gender: ☐ Male ☐ Female

Address (Street, City, State, Zip Code):

Phone Numbers: Daytime: Evening: Personal Cell:

Email Address:

May we have your authorization to leave confidential medical and benefit information on your personal cell phone? ☐ Yes ☐ No and/or request this by E-mail? ☐ Yes ☐ No

Acknowledge your electronic acceptance by checking the box below:

☐ I understand that checking this box constitutes a legal signature confirming that I acknowledge and warrant the truthfulness of the information provided in this document.

Date (Month / Day / Year):

Please indicate any other sources of medical insurance under which you, the Claimant, are covered:

☐ Medicare ☐ Medicaid ☐ Employer's Policy◆ ☐ Spouse's Employer's Policy◆ ☐ Any other medical policy◆

◆ If Yes, and the Policy under which you are making a Claim provides coverage on an Excess basis, please include the other Carrier's Explanation of Benefits (EOBs) for each medical bill submitted. Please consult your Authorized Policyholder Administrator or Everest, if you are unsure of the Policy's scope of coverage.

B. Incident, Loss, Accident or Illness Information

Place where Incident, Loss, Accident or Illness Occurred:

Date (Month / Day / Year): Time: ☐ am ☐ pm

Full Description/Details of the Accident (attach additional notes if necessary):

C. Personal Accident & Medical Expenses *Please attach (a) copy of your ticket, (b) original medical report from hospital or treating doctor and (c) original medical receipts and bills.*

Did you call Healix Global Travel Assistance Services? ☐ Yes ☐ No If Yes, Reference/Case #:

Have you ever suffered this or a similar condition or recurrence of a previous injury or illness? ☐ Yes ☐ No

If Yes, please specify:

For Claims due to Injury, please complete the following:

Nature of Accident (When, where and how did the injury occur)?

Name and Address of law enforcement agency involved and Case Number (if applicable):

For Claims due to Illness, please complete the following:

Nature of Illness (exact nature of pathology):

What were the first symptoms? When did symptoms begin?

Has the Claimant had this illness before? ☐ Yes ☐ No If Yes, when?

For Claims due to Injury or Illness, please complete the following:

Date of Initial Treatment (Month / Day / Year):

Nature of treatment received to date:

Is further treatment anticipated? ☐ Yes ☐ No

If Yes, nature and duration of expected treatment?

Provide the Name, Address and Phone Number of attending Physician below:

State Net Amount you wish to claim: $

D. Travel Trip Delay/Interruption *Please attach (a) flight itinerary, (b) boarding pass, (c) written confirmation from the Common Carrier on the duration of the delay and reasons for the delay, (d) written confirmation from the Common Carrier of any compensation received, (e) original invoices/receipts of any emergency expenses incurred due to delay/interruption.*

Original Trip Details

Date (Month / Day / Year):

Time: ☐ am ☐ pm

Place of Departure:

Flight/Train/Boat #:

Name of Airline/Carrier:

Delayed/Interrupted Trip Details

Date (Month / Day / Year):

Time: ☐ am ☐ pm

Place of Departure:

Flight/Train/Boat #:

Name of Airline/Carrier:

List of reasonable emergency expenses you incurred due to delay/interruption:

Description	**Date & Time of Purchase**	**Purchase Price**

E. Trip Cancellation *Please attach (a) doctor or hospital report, b) death certificate, c) relativity certificate, d) ticket or travel package cost, e) details of compensation received from travel agent, tour operator or Common Carrier, d) official receipts of any additional travelling expenses incurred.*

When and where was the trip booked?

Intended Departure Date (Month / Day / Year): Date Canceled: (Month / Day / Year):

Why was trip cancelled?

Initial Amount paid by you: Amount recovered from other sources:

Amount Claimed:

F. Baggage Delay *Please attach (a) copy of your ticket, (b) boarding pass, (c) baggage tags, (d) written confirmation from the Common Carrier on the duration of the delay and reasons for the delay, (e) written confirmation from the Common Carrier of any compensation received.*

Flight Details

Arrival Date: (Month / Day / Year):

Arrival Time: ☐ am ☐ pm

Place of Departure:

Flight Number:

Name of Airline:

Collection of Delay Baggage

Date: (Month / Day / Year):

Time: ☐ am ☐ pm

Place:

G. Personal Property *Please attach (a) copy of your ticket, (b) boarding pass, (c) baggage tags, (d) Property Irregularity Report, (e) written confirmation from the Common Carrier of any compensation received.*

Provide name of Airline/Carrier, Police Station, or other authorities where report lodged below:

Date of Travel:

Departure

Date (Month / Day / Year):

Time: ☐ am ☐ pm

Place of Departure:

Arrival

Date (Month / Day / Year):

Time: ☐ am ☐ pm

Place of Departure:

Give details of amount claimed:

Item	Description	When and Where Purchased	Original Purchase Price	Depreciation - Wear & Tear	Amount Claimed

CERTIFICATION

I certify that the above information furnished by me on the Claimant's Statement is true and accurate to the best of my knowledge. I further certify I have read the fraud statements below and understand the laws of my state of residence. I also authorize any physician/hospital that has attended me or my dependent to disclose information acquired for claim payment purposes.

Acknowledge your electronic acceptance by checking the box below:

☐ I understand that checking this box constitutes a legal signature confirming that I acknowledge and warrant the truthfulness of the information provided in this document.

Name of Claimant: **Date** (Month / Day / Year):

FRAUD STATEMENTS

APPLICABLE IN ALABAMA, ARKANSAS, MARYLAND, NEW MEXICO, TEXAS, and WEST VIRGINIA
Any person who knowingly (or willfully)* presents a false or fraudulent claim for payment of a loss or benefit or knowingly (or willfully)* presents false information in an application for insurance is guilty of a crime and may be subject to (civil)** fines and (criminal penalties)** confinement in prison. *Applies in MD only. ** Applies in NM only.

APPLICABLE IN ALASKA, CONNECTICUT, DELAWARE, GEORGIA, IDAHO, ILLINOIS, INDIANA, IOWA, KANSAS, KENTUCKY, LOUISIANA, MASSACHUSETTS, MICHIGAN, MINNESOTA, MISSISSIPPI, MISSOURI, MONTANA, NEBRASKA, NEVADA, NEW JERSEY, NORTH DAKOTA, RHODE ISLAND, SOUTH CAROLINA, SOUTH DAKOTA, UTAH, WISCONSIN, and WYOMING
Any person who knowingly and with intent to defraud any insurance company or another person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects the person to criminal and civil penalties and/or imprisonment.

APPLICABLE IN ARIZONA
For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

APPLICABLE IN CALIFORNIA
General: For your protection California law requires the following to appear on this form.
Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

APPLICABLE IN COLORADO
It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable for insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

APPLICABLE IN DISTRICT OF COLUMBIA
WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

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

APPLICABLE IN FLORIDA
General: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

APPLICABLE IN HAWAII
For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

APPLICABLE IN LOUISIANA
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

APPLICABLE IN MAINE
It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits.

APPLICABLE IN NEW HAMPSHIRE
Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud as provided in RSA 638:20.

APPLICABLE IN NEW YORK
General: 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 of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

APPLICABLE IN NORTH CAROLINA
Any person who knowingly presents false information in an application for insurance or viatical settlement contract or a viatical settlement purchase agreement is guilty of a felony and may be subject to fines and confinement in prison.

APPLICABLE IN OHIO
Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

APPLICABLE IN OKLAHOMA
General: WARNING: 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.

APPLICABLE IN OREGON
Any person who knowingly and with intent to defraud or solicit another to defraud the insurer by submitting an application or by filing a claim containing a misstatement, misrepresentation, omission, or false statement as to any material fact may be committing a fraudulent insurance act, which may be a crime and subject the person to criminal and civil penalties.

APPLICABLE IN PENNSYLVANIA
General: 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 of 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.

APPLICABLE IN PUERTO RICO
Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances [be] present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

APPLICABLE IN TENNESSEE, VIRGINIA AND WASHINGTON
General: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.