NAHGA
CLAIM SERVICES
WHERE STELLAR SERVICE IS NO ACCIDENT

ACCIDENT CLAIM FORM

Please print or type. Incomplete forms will be returned
SEND COMPETED FORM & BILLS TO:

NAHGA Claim Services
P.O. Box 189
Bridgton, Maine 04009-0189
Email: claims@nagha.com
Fax: (207) 647-4569

INSTRUCTIONS

- All fields must be completed
- Part 1 - Must be completed by the Policyholder
- Part 2 and 3 - Must be completed by Claimant or by the Parent or Guardian, if the Claimant is a minor
- Send copies of itemized bills showing provider's name, address, tax ID number, diagnosis and procedures codes.
- Attach explanation of benefits, additional bills with record of payment or denial from primary insurance carrier. This does not apply if the accident policy provides primary coverage
- All benefits will be payable to the physicians and providers, unless accompanied by paid receipts

PART 1 - POLICYHOLDER REPORT

1)	Name of Policyholder	Mendocino-Lake CCD
2)	Policy Number	98391
3)	Policyholder Address	1000 Hensley Creek Rd, Ukiah, CA 95482
4)	Policyholder Contact's Email Address	jvaughn@studentinsuranceusa.com
5)	Policyholder Contact's Phone Number	(501) 940-8063
6)	Nature of Injury (Describe, fully indicate what part of the body was injured) **Must be a bodily injury due to an Accident**	
7)	Describe how the accident occurred, provide all details **Attach a separate sheet, if necessary**	
8)	Did the Accident occur:	
	a. During a Policyholder supervised sponsored activity	☐ Yes ☐ No
	b. During a Policyholder sponsored activity	☐ Yes ☐ No
	c. During scheduled Policyholder hours	☐ Yes ☐ No
	d. While traveling to or from a Policyholder sponsored or supervised activity	☐ Yes ☐ No
	e. While Traveling to or from the Policyholder's location and their home	☐ Yes ☐ No
9)	Date and Time of Accident	
	Place of Accident	
10)	Name and Title of Person Supervising Activity	
	Was he or she a witness	☐ Yes ☐ No

Signature of Authorized Policyholder Representative	Title	Date

PART 2 - CLAIMANT/ PARENT OR GUARDIAN INFORMATION

1)	Claimant's Name (Last, First)	
2)	Claimant's Social Security Number	
3)	Claimant's Date of Birth	
4)	Claimant's Sex	☐ Male ☐ Female
5)	Name of Parent/ Guardian	
6)	Parent/ Guardian's Social Security Number	
7)	Parent/ Guardian's Email Address	
8)	Parent/ Guardian's Address	
9)	List other Accident or Medical Insurance currently enforce (Attach a separate sheet if necessary) **Type of Policy and Policy Number**	
10)	Is the Claimant covered by a Medicare Policy	☐ Yes ☐ No

PART 3 - AUTHORIZATION

PERSONAL INFORMATION NOTICE AND CONSENT: I understand that the information provided by me on this claim form and otherwise in respect of my claim, is required by Pan-American Life Insurance Company or its representatives (the "Insurer") to assess my entitlement to benefits, determine if coverage is in effect and co-coordinate coverage with other insurers. I consent to the collection, use, retention and disclosure of my personal information and that of my dependents, including any information collected in this claim form or otherwise obtained by the Insurer, its affiliates and any independent third parties for the purposes of administering, adjudicating, and/or servicing my claim as well as exchanging information with agents, brokers, third party administrators or any other independent third parties for the purposes of determining the status, outcome or resolving any issues in connection with my claim. I understand that my personal information and that of my dependents may be stored within or outside the United States for processing, storage, analysis, or disaster recovery, and under applicable law, may be subject to disclosure to domestic or foreign governments, courts, law enforcement or regulatory agencies. I understand that I may revoke my consent at any time in writing and acknowledge that should I do so, my claim may not be adjudicated. In cases of suspected fraud concerning this claim, I agree that the Insurer may investigate and share information with regulatory bodies, government or police agencies, other insurers, healthcare professionals, the group policyholder or my employer, if applicable.

I, the undersigned authorize any hospital or other medical-care institution, physician or other medical professional, pharmacy, insurance support organization, governmental agency, group policyholder, insurance company or reinsurance company, workers compensation board or similar plan or organization, association or institution, employer or benefit plan administrator to furnish to Pan-American Life Insurance Company or its representatives, any and all information with respect to any injury or sickness suffered by, the medical history of, or any consultation, prescription or treatment provided to, the person whose death, injury, sickness or loss is the basis of claim and copies of all of that person's hospital or medical records, including information relating to mental illness and use of drugs and alcohol, to determine eligibility for benefit payments under the Policy Number identified above. I authorize the group policyholder, employer or benefit plan administrator to provide Pan-American Life Insurance Company with financial and employment-related information. I understand that this authorization is valid for a period of two (2) years from the date hereof, and that a copy of this authorization shall be considered as valid as the original. I understand that I or my authorized representative may request a copy of this authorization.

Signature of Claimant or Parent or Guardian	Date

AUTHORIZATION TO PAY BENEFITS TO PROVIDER: I hereby authorize payment directly to the Provider of service for medical benefits, if any, otherwise payable to me for services rendered but not to exceed the reasonable and customary charge for those services.

Signature of Claimant or Parent or Guardian	Date

Note: If you do not sign the authorized to pay benefits to the provider and would like payment directly to you, you MUST submit paid receipts for each bill.

Dear Insured: *Insurance is underwritten by Pan-American Insurance Company. Below is a listing of the fraud language that your State Department of Insurance requires us to give to you. Please first locate your state of residence and then read the fraud language that pertains to your state. Thank you.*

Connecticut	Massachusetts	Nebraska	South Dakota
Georgia	Michigan	North Carolina	Utah
Hawaii	Missouri	North Dakota	Vermont
Iowa	Mississippi	Nevada	Wisconsin
Illinois	Montana	South Carolina	Wyoming

Generic Fraud Warning (to be used for above states only) 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.

Alabama - Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines, or confinement in prison, or any combination thereof.

Alaska - A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

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.

Arkansas, Louisiana, Rhode Island and West Virginia - 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.

California - For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

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 from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

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.

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.

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

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

Indiana - A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

KANSAS: ANY PERSON, WHO KNOWINGLY AND WITH INTENT TO DEFRAUD, PRESENTS, CAUSES TO BE PRESENTED OR PREPARES WITH KNOWLEDGE OR BELIEF THAT IT WILL BE PRESENTED TO OR BY AN INSURER, PURPORTED INSURER, BROKER OR ANY AGENT THEREOF, ANY WRITTEN, ELECTRONIC IMPULSE, FACISIMILE, MAGNETIC, ORAL, OR TELEPHONIC COMMUNICATION OR STATEMENT AS PART OF, OR IN SUPPORT OF, AN APPLICATION FOR THE ISSUANCE OF, OR THE RATING FOR AN INSURANCE POLICY OR COMMERCIAL INSURANCE, OR A CLAIM FOR PAYMENT OR OTHER BENEFIT PURSUANT TO AN INSURANCE POLICY FOR COMMERCIAL OR PERSONAL INSURANCE WHICH SUCH PERSON KNOWS TO CONTAIN MATERIALLY FALSE INFORMATION CONCERNING ANY FACT MATERIAL THERETO, OR CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRADUALENT INSURANCE ACT.

Kentucky - 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, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

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 a denial of insurance benefits.

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

Minnesota - A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

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.

New Jersey - Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico - 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 CIVIL FINES AND CRIMINAL PENALTIES.

Ohio and Oregon - 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.

Oklahoma - 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.

Pennsylvania - Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

Tennessee, Virginia and Washington State - 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.

Texas - Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.