SISC II
SELF-INSURED SCHOOLS OF CALIFORNIA

Schools Helping Schools

STUDENT ACCIDENT COVERAGE

Revised 4/2011

TO: Parent(s)/Guardian

SUBJECT: Student Accident Coverage Reporting and Claim Filing Procedure

Student Accident Coverage is SECONDARY to any other insurance which provides medical benefits to your child including Healthy Families. SISC is primary to Medi-Cal and Tricare. A claim must be filed with your primary insurance carrier (e.g., Blue Cross, Blue Shield) at the same time you file a Student Accident Coverage claim. ***If you subscribe to an HMO (Health Maintenance Organization), you must use it.***

If you have primary insurance, a copy of the "Explanation of Benefits" (how your insurance has processed the claim) from your insurance carrier is needed to process the Student Accident Claim.

Note: Student Accident Coverage has a maximum benefit of $2,500.00 for services rendered as a result of bodily injury. Benefits are only payable for services rendered within one year of the date of the injury. Physical therapy and chiropractic services are subject to additional limitations. The completed SISC claim form must be submitted to SISC within one year (52 weeks) of the date of injury. This is a brief outline of the plan and is not to be accepted or construed as a substitute for the provisions of the contract.

ALL SECTIONS NEED TO BE COMPLETED OR YOUR CLAIM WILL BE RETURNED.

1. Report accidental injury to appropriate school official immediately.

2. Have designated school employee complete and sign the school's section of the claim form.

3. The claim form **must be filled out completely**—all areas need the specific information which is requested and the parents/guardians need to sign all the appropriate spaces.

4. Give a copy of the completed claim form to all providers to be billed directly to SISC.

OR

5. Send completed claim form, itemized bills and Explanations of Benefits (EOBs) if applicable to:
   SISC - Student Accident Coverage
   P.O. Box 1847
   Bakersfield, CA 93303-1847

For your personal records, please keep a copy of all submitted paperwork.

Any questions concerning Student Accident Coverage should be directed to this office at (661) 636-4710.

DL:mrp
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P. O. Box 1847 ◆ Bakersfield, CA 93303-1847 ◆ http://www.kern.org/sisc/
1300 17th Street - CITY CENTRE ◆ Bakersfield, CA ◆ (661) 636-4710 ◆ FAX (661) 636-4418

PARA: Los Padres de Familia/Tutor

ASUNTO: Procedimiento a seguir para reportar y recibir cobertura al presentar una reclamación cuando ocurre un accidente escolar.

La cobertura para Accidentes Escolares es SECUNDARIO a cualquier tipo de seguro médico que su hijo tenga, incluso Healthy Families. La cobertura SISC es primaria a Medi-Cal y Tricare. El reclamo se debe presentar a su aseguranza primaria (por ejemplo, Blue Cross, Blue Shield), al mismo tiempo que se presente la reclamación de Cobertura Para Accidentes Escolares. ***Si usted pertenece a una organización de seguro prepagada (HMO – Organización de Mantenimiento de Salud), usted debe utilizar esos servicios.***

Si usted tiene seguro médico primario, se necesita copia del reporte de sus beneficios de salud (reporte que explica como su seguro médico ha procesado su reclamo), para poder tramitar la reclamación de Cobertura Para Accidentes Escolares.

Nota: La cobertura para Accidentes Escolares tiene una indemnización máxima de $2,500.00 por servicios médicos prestados como resultado de una lesión corporal. Este dinero se paga únicamente por servicios médicos prestados dentro del primer año a partir de la fecha del accidente. Los servicios de fisioterapia, y tratamiento quiropráctico están sujetos a restricciones adicionales. El formulario de reclamación completo se debe mandar a SISC dentro del año siguiente (52 semanas) después de la fecha de la lesión.

SE DEBEN LLENAR TODAS LAS SECCIONES O SU FORMA DE RECLAMO SERÁ DEVUELTA.

1. Reporte inmediatamente lesiones accidentales al representante de la escuela que corresponda.

2. Pida que el representante designado por la escuela llene y firme la parte correspondiente a la escuela.

3. El formulario de reclamación **debe llenarse completamente** -- todas las secciones deben tener la información específica requerida, y los padres o tutores del niño deben firmar en los espacios correspondientes.

4. Dele una copia del formulario de reclamación a los proveedores de servicios médicos para que manden los cobros directamente a SISC.

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5. Mande la forma de reclamo, adjunte los estados de cuenta detallados y copias de la explicación de beneficios (esto último es solo en caso de que tenga un seguro médico primario) a:

   SISC - Student Accident Coverage
   P.O. Box 1847
   Bakersfield, CA 93303-1847

Antes de enviar los documentos, es recomendable que haga copias para sus archivos personales.

Cualquier pregunta concerniente a la Cobertura Para Accidentes Escolares debe dirigirse a esta oficina llamando al teléfono (661) 636-4710.

DL:mrp
Adjunto

File # _____

SISC CLAIM FORM

❑ STUDENT ACCIDENT
❑ SUPPLEMENTAL COVERAGE

(Grades Preschool through 12)

Mail To: SISC Student Accident Claims, P.O. Box 1847,
Bakersfield, CA 93303-1847 - (661) 636-4710

TO BE COMPLETED BY SCHOOL OFFICIAL

Did the accident occur **during** (*Check Yes or No*)

A. Non-school related activity?	❑ Yes	❑ No
B. Supervised school activity?	❑ Yes	❑ No
C. Field trip activity?	❑ Yes	❑ No
D. Supervised off-campus activity?	❑ Yes	❑ No
E. Sponsored and supervised travel?	❑ Yes	❑ No
F. Supervised athletic practice/competition?	❑ Yes	❑ No

Sport_____

Name and Title of Supervising School Authority:

Name_____

Title _____

Signature _____

School District _____

School Name_____

STUDENT INFORMATION

STUDENT'S FULL NAME | MAILING ADDRESS | CITY | ZIP

DATE OF BIRTH | SOCIAL SECURITY # | GRADE | SEX ❑ M ❑ F | TELEPHONE

1. Give full description of injury. Tell when, where, and how it happened.

2. Give exact date and time when injury occurred. Date: _____ Time:_____ a.m. _____p.m.

3. When did you first consult a physician for this condition? Date: _____

TO BE COMPLETED BY PARENT
PARENT INFORMATION

SISC Accident Coverage is secondary to your private health insurance.

1. Father's Name_____ EMPLOYED: Yes_____ No_____

Father's Employer _____ Employer Telephone (_____)_____

Individual and/or
Group Insurance Company _____ Policy # _____

SOCIAL SECURITY # _____Is child covered by this insurance? Yes_____ No_____

I authorize the release of any information necessary to process this claim.

Father's
Signature_____Date_____

I authorize payment of medical benefits to physician or supplier of service.

Father's
Signature_____Date_____

2. Mother's Name _____ EMPLOYED: Yes_____ No_____

Mother's Employer _____ Employer Telephone (_____)_____

Individual and/or
Group Insurance Company _____ Policy # _____

SOCIAL SECURITY # _____Is child covered by this insurance? Yes_____ No_____

I authorize the release of any information necessary to process this claim.

Mother's
Signature_____Date_____

I authorize payment of medical benefits to physician or supplier of service.

Mother's
Signature_____Date_____

IMPORTANT - PARENT'S RESPONSIBILITY: All hospital and doctor bills must be itemized.
NOTICE TO PROVIDERS: A copy of this claim form needs to be attached to your bill.