SISC II
SELF-INSURED SCHOOLS OF CALIFORNIA
Schools Helping Schools

STUDENT ACCIDENT COVERAGE

# Tackle Football

TO: Parent/Guardian

SUBJECT: SISC ***Tackle Football*** Coverage

SISC Tackle Football Coverage is **secondary** to any other insurance which provides medical benefits to your child, including Healthy Families. 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 Tackle Football Claim. ***If you subscribe to an HMO (Health Maintenance Organization), we recommend you use it to get maximum benefits.***

SISC is **primary** to Medi-Cal and Tricare. SISC becomes primary if you have no other insurance coverage.

Claims submitted to SISC Tackle Football Coverage are paid according to a schedule of benefits. A schedule of benefits is included on the back of this claim form and in the application brochure. **Please read it carefully.** In some cases, not all charges will be paid, leaving a balance that is your responsibility. When payments are made, you will receive an Explanation of Benefits (EOB) showing what was paid and any remaining balance due.

**The completed Tackle Football form must be submitted to SISC within one year of the date of injury. Benefits are only payable for services rendered within one year of the date of the injury. Treatment must begin within 30 days of the injury.**

SUBMITTING A CLAIM:

1. Report the injury to the appropriate school official immediately.
2. Obtain a Tackle Football claim form and have the appropriate school official complete and sign the school's section of the form.
3. Complete **all** remaining sections of the form, including signatures.
4. Give a copy of the claim form to all providers involved with your child's treatment so they can bill SISC directly.

**OR**

5. Send the completed SISC 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.

Please direct any questions you may have regarding Tackle Football Coverage to (661) 636-4710

File # _____

# SISC TACKLE FOOTBALL CLAIM FORM

☐ Tackle Football Accident
☐ Supplemental Coverage

*Mail To:* SISC Tackle Football, P.O. Box 1847,
Bakersfield, CA 93303-1847 - (661) 636-4710

## TO BE COMPLETED BY SCHOOL OFFICIAL

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

A. During school sponsored tackle football practice? ☐ Yes ☐ No
B. During school sponsored tackle football competition? ☐ Yes ☐ No
C. During school sponsored and supervised tackle football transportation? ☐ Yes ☐ No

Name and Title of Supervising School Authority:

Name _____
Title _____
Signature _____
School District _____
School Name _____

## STUDENT INFORMATION – To Be Completed By Parent

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

| DATE OF BIRTH | GRADE | SEX | TELEPHONE NUMBER |
|---|---|---|---|
| | | ☐ M ☐ F | |

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: _____

## 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 – Give a <u>copy</u> of this form to ALL providers.**

## SUMMARY OF BENEFITS

| | |
|---|---|
| Surgical Allowances | 100% to $1,000.00 |
| X-RAYS in or out of hospital including reading or interpretation thereof but excluding dental X-rays, not to exceed the amount specified below as the result of any one accident. | $200.00 |
| Diagnostic Imaging (MRI/CAT scan) Aggregate charges | $750.00 |
| Anesthesia Allowance | up to $250.00 |
| Assistant Surgeon Paid | up to $250.00 |
| Physician's Services: | |
| Initial Call | $45.00 |
| Initial ER Call | $75.00 |
| Subsequent Calls | $25.00 |
| Physical therapy/Chiropractic Services | 15 visits @ $25.00 |
| Hospital Room and Board, per day, up to | Semi-Private Rate |
| Intensive Care, per day, up to | 2 x Semi-Private Rate |
| Hospital Miscellaneous, Inpatient Expense, up to | 80% to $5,000.00 |
| Emergency Room Care, up to | $500.00 |
| Dental, per tooth | $500.00 |
| Outpatient Surgery Facilities (room and supplies) | 80% to $2,000.00 |
| Orthopedic Appliances prescribed by a Physician | Usual and customary |
| Casting Supplies | Usual and customary |
| Land Ambulance | Usual and customary |
| Outpatient Drugs | Usual and customary |
| Outpatient Lab Benefit | $75.00 |
| Eye Glass Replacement of broken eye glasses, frames, lenses resulting from a covered accident. This benefit is payable only if an injury which requires medical or surgical treatment results from the same accident. Routine Refractions or Routine Eye Examinations are not covered | $100.00 |