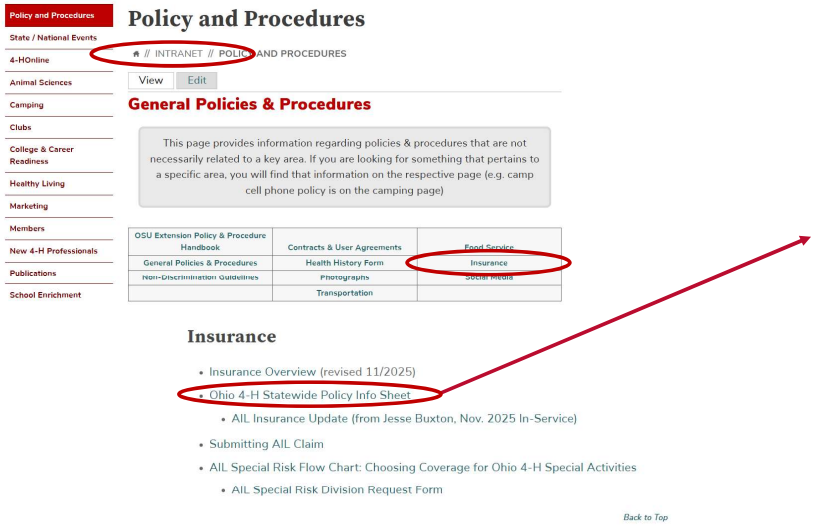
American Income Life Special Risk Division: When Needing to Submit a Claim

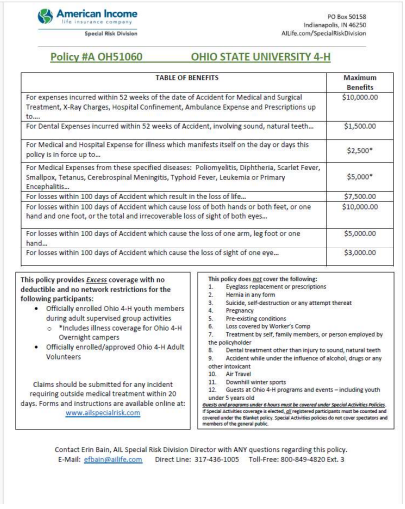
We sustain life.

THE OHIO STATE UNIVERSITY EXTENSION

Accident Insurance

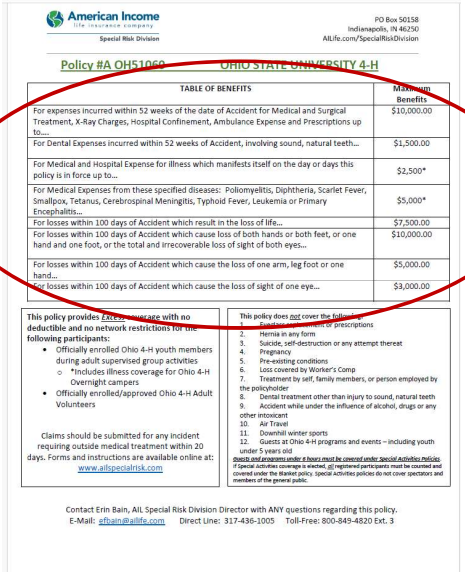
Where to locate the statewide policy information





What is covered

Know this information before you need it!



American Income
life insurance company
Special Risk Division

PO Box 50158
Indianapolis, IN 46250
AILife.com/SpecialRiskDivision

Policy #A OH51069 OHIO STATE UNIVERSITY 4-H

TABLE OF BENEFITS	Maximum Benefits
For expenses incurred within 52 weeks of the date of Accident for Medical and Surgical Treatment, X-Ray Charges, Hospital Confinement, Ambulance Expense and Prescriptions up to....	$10,000.00
For Dental Expenses incurred within 52 weeks of Accident, involving sound, natural teeth...	$1,500.00
For Medical and Hospital Expense for illness which manifests itself on the day or days this policy is in force up to...	$2,500*
For Medical Expenses from these specified diseases: Poliomyelitis, Diphtheria, Scarlet Fever, Smallpox, Tetanus, Cerebrospinal Meningitis, Typhoid Fever, Leukemia or Primary Encephalitis...	$5,000*
For losses within 100 days of Accident which result in the loss of life...	$7,500.00
For losses within 100 days of Accident which cause loss of both hands or both feet, or one hand and one foot, or the total and irrecoverable loss of sight of both eyes...	$10,000.00
For losses within 100 days of Accident which cause the loss of one arm, leg foot or one hand...	$5,000.00
For losses within 100 days of Accident which cause the loss of sight of one eye...	$3,000.00

This policy provides Excess coverage with no deductible and no network restrictions for the following participants:

- Officially enrolled Ohio 4-H youth members during adult supervised group activities
  - *Includes illness coverage for Ohio 4-H Overnight campers
- Officially enrolled/approved Ohio 4-H Adult Volunteers

Claims should be submitted for any incident requiring outside medical treatment within 20 days. Forms and instructions are available online at: www.ailspecialrisk.com

This policy does not cover the following:
1. Expenses for items or prescriptions
2. Hernia in any form
3. Suicide, self-destruction or any attempt thereat
4. Pregnancy
5. Pre-existing conditions
6. Loss covered by Worker's Comp
7. Treatment by self, family members, or person employed by the policyholder
8. Dental treatment other than injury to sound, natural teeth
9. Accident while under the influence of alcohol, drugs or any other intoxicant
10. Air Travel
11. Downhill winter sports
12. Guests at Ohio 4-H programs and events – including youth under 5 years old

events and programs under 4 hours must be covered under Special Activities Policies
If Special Activities coverage is elected, all registered participants must be counted and covered under the Blanket policy. Special Activities policies do not cover spectators and members of the general public.

Contact Erin Bain, AIL Special Risk Division Director with ANY questions regarding this policy.
E-Mail: efbain@aillife.com Direct Line: 317-436-1005 Toll-Free: 800-849-4820 Ext. 3

- What is covered: Found in Table of Benefits

Make sure to note the things that are NOT covered

When something happens...

In the midst of the situation…

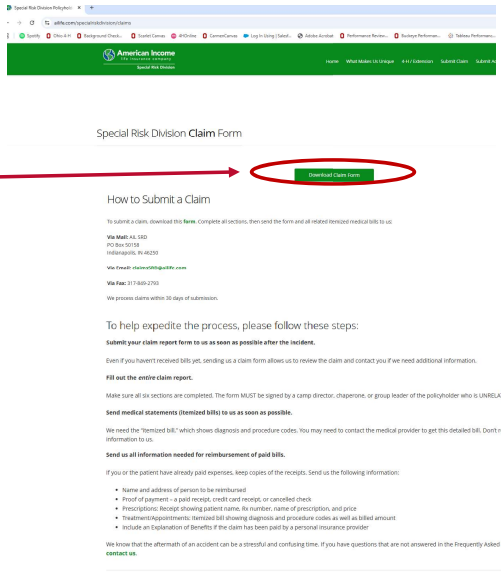
- Get appropriate care for the individual
  - Send policy number with patient
- Complete accident/injury report (go.osu.edu/AccidentInjuryReport)
  - Include details and statements from witnesses, medical professionals, etc. as necessary. This will help you later as you need to refer to information about the situation.

As soon as the patient is taken care of

- Submit claim report to AIL as soon as possible after the incident
  - Within 20 days is best practice, but 90 days from the incident is a hard deadline. After 90 days, there is a risk of an automatic denial of the claim for lack of timely filing.
- Key things to help expedite the process
  - Fill out the *entire* claim report and submit via email directly to claimssrd@aillife.com
  - Send medical statements (itemized bills) to AIL as soon as possible
  - Send all information needed for reimbursement of paid bills
    - Make sure all documents are full page pdf or other good quality scans vs. photos or copies that may have lower quality.

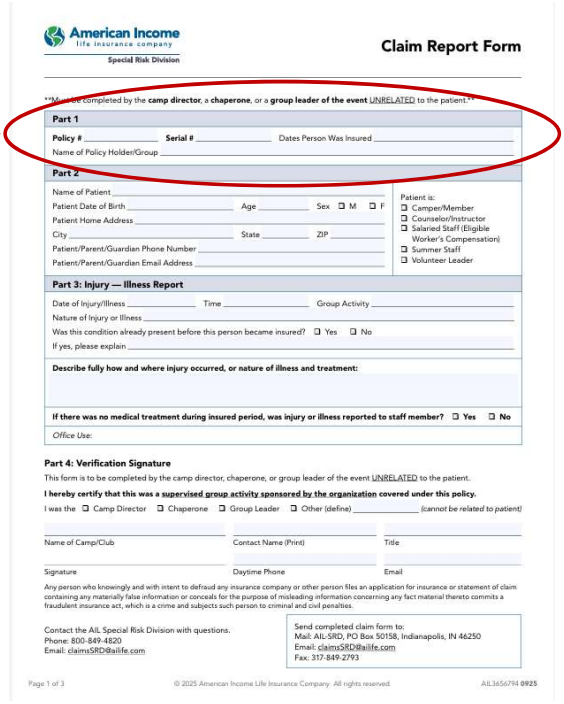
Submitting the actual claim

- Go to American Income Life: https://www.ailife.com/specialriskdivision/claims
  - Download Claim Form
- Refer to key information on the statewide policy info sheet
- Check out the Claims FAQ on the AIL website for additional helpful information



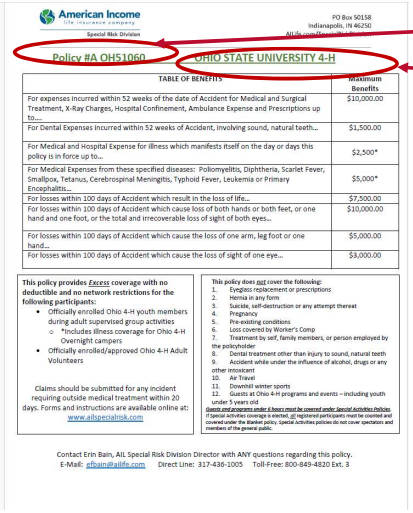
Claim Form

- Part 1 of the information is standard in the Ohio 4-H blanket policy—see the next slide for where to locate this information



Statewide Policy Info Sheet

Information you will need when submitting AIL Claim (through blanket policy; see next slide for special activities)



American Income
Life Insurance Company
Special Risk Division

PO Box 50158
Indianapolis, IN 46250

Policy #A OH51060

OHIO STATE UNIVERSITY 4-H

TABLE OF BENEFITS	Maximum Benefits
For expenses incurred within 52 weeks of the date of Accident for Medical and Surgical Treatment, X-Ray Charges, Hospital Confinement, Ambulance Expense and Prescriptions up to....	$10,000.00
For Dental Expenses incurred within 52 weeks of Accident, involving sound, natural teeth...	$1,500.00
For Medical and Hospital Expense for illness which manifests itself on the day or days this policy is in force up to...	$2,500*
For Medical Expenses from these specified diseases: Poliomyelitis, Diphtheria, Scarlet Fever, Smallpox, Tetanus, Cerebrospinal Meningitis, Typhoid Fever, Leukemia or Primary Encephalitis...	$5,000*
For losses within 100 days of Accident which result in the loss of life...	$7,500.00
For losses within 100 days of Accident which cause loss of both hands or both feet, or one hand and one foot, or the total and irrecoverable loss of sight of both eyes...	$10,000.00
For losses within 100 days of Accident which cause the loss of one arm, leg foot or one hand...	$5,000.00
For losses within 100 days of Accident which cause the loss of sight of one eye...	$3,000.00

This policy provides *Excess* coverage with no deductible and no network restrictions for the following participants:

- Officially enrolled Ohio 4-H youth members during adult supervised group activities
  - *Includes illness coverage for Ohio 4-H Overnight campers
- Officially enrolled/approved Ohio 4-H Adult Volunteers

Claims should be submitted for any incident requiring outside medical treatment within 20 days. Forms and instructions are available online at: www.ailspecialrisk.com

This policy does not cover the following:

1. Eyeglass replacement or prescriptions
2. Hernia in any form
3. Suicide, self-destruction or any attempt thereat
4. Pregnancy
5. Pre-existing conditions
6. Loss covered by Worker's Comp
7. Treatment by self, family members, or person employed by the policyholder
8. Dental treatment other than injury to sound, natural teeth
9. Accident while under the influence of alcohol, drugs or any other intoxicant
10. Air Travel
11. Downhill winter sports
12. Guests at Ohio 4-H programs and events – including youth under 5 years old

Guests and programs under 4 hours must be covered under Special Activities Policies.
If special activities coverage is elected, all registered participants must be counted and covered under the Blanket policy. Special activities policies do not cover spectators and members of the general public.

Contact Erin Bain, AIL Special Risk Division Director with ANY questions regarding this policy.
E-Mail: efbain@ailife.com Direct Line: 317-436-1005 Toll-Free: 800-849-4820 Ext. 3

Policy Number

Name of Policy Holder

- Dates insured = 1/1-12/31 of the current calendar year
- Serial number: applies to special activities and not applicable for this submission

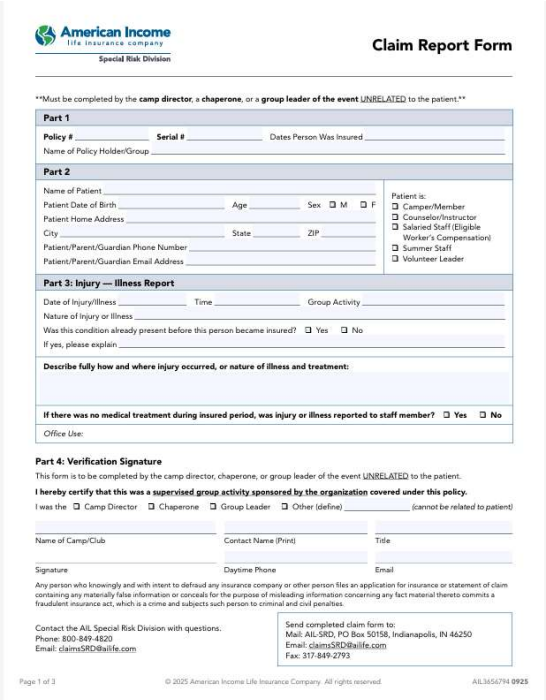
Special Activities Coverage Information

Specific information

- **Name of Policy Holder:** What you submitted when completing the request for coverage
- **Dates:** what is submitted when electing this coverage
- **Serial number:** will find the policy number (718 A, B, or C based on the level of coverage chosen in advance of the event) and the Serial Number in your Confirmation of Coverage email from AIL

Claim Form

- You will provide the rest of the information (e.g. patient information, report, signatures, etc.) based on the information you know / what occurred, and follow the steps outlined on the claim form
- NOTE: You may need to check the patient's information in your enrollment/registration process



American Income Life Insurance Company
Special Risk Division

Claim Report Form

Must be completed by the **camp director, a **chaperone**, or a **group leader of the event** UNRELATED to the patient.**

Part 1

Policy # _____ **Serial #** _____ Dates Person Was Insured _____
Name of Policy Holder/Group _____

Part 2

Name of Patient _____
Patient Date of Birth _____ Age _____ Sex ❑ M ❑ F
Patient Home Address _____
City _____ State _____ ZIP _____
Patient/Parent/Guardian Phone Number _____
Patient/Parent/Guardian Email Address _____

Patient is:
❑ Camper/Member
❑ Counselor/Instructor
❑ Salaried Staff (Eligible Worker's Compensation)
❑ Summer Staff
❑ Volunteer Leader

Part 3: Injury — Illness Report

Date of Injury/Illness _____ Time _____ Group Activity _____
Nature of Injury or Illness _____
Was this condition already present before this person became insured? ❑ Yes ❑ No
If yes, please explain _____

Describe fully how and where injury occurred, or nature of illness and treatment:

If there was no medical treatment during insured period, was injury or illness reported to staff member? ❑ Yes ❑ No

Office Use:

Part 4: Verification Signature

This form is to be completed by the camp director, chaperone, or group leader of the event UNRELATED to the patient.

I hereby certify that this was a supervised group activity sponsored by the organization covered under this policy.

I was the ❑ Camp Director ❑ Chaperone ❑ Group Leader ❑ Other (define) _____ (cannot be related to patient)

Name of Camp/Club | Contact Name (Print) | Title

Signature | Daytime Phone | Email

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.

Contact the AIL Special Risk Division with questions.
Phone: 800-849-4820
Email: claimsSRD@ailife.com

Send completed claim form to:
Mail: AIL:SRD, PO Box 50158, Indianapolis, IN 46250
Email: claimsSRD@ailife.com
Fax: 317-849-2793

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American Income life insurance company
Special Risk Division

PO Box 50158
Indianapolis, IN 46250
AILife.com/SpecialRiskDivision

Policy #A OH51060 OHIO STATE UNIVERSITY 4-H

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6. Loss covered by Worker's Comp
7. Treatment by self, family members, or person employed by the policyholder
8. Dental treatment other than injury to sound, natural teeth
9. Accident while under the influence of alcohol, drugs or any other intoxicant
10. Air Travel
11. Downhill winter sports
12. Guests at Ohio 4-H programs and events – including youth under 5 years old

Guests and programs under 6 hours must be covered under Special Activities Policies. If Special Activities coverage is elected, *all* registered participants must be counted and covered under the Blanket policy. Special Activities policies do not cover spectators and members of the general public.

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E-Mail: efbain@ailife.com Direct Line: 317-436-1005 Toll-Free: 800-849-4820 Ext. 3

Program Participant Incident/Injury Report

(If OSU employee is injured, use Employee Accident Report: hr.osu.edu/public/documents/forms/accidentrpt.pdf)

☐ Incident ☐ Injury ☐ Both **Date and Time Occurred** ___/___/___ ; _____ am/pm

Date and Time Reported (If not at time of occurrence.) ___/___/___ ; _____ am/pm

Program Sponsor (County/unit) _____

Where Occurred Indicate name of program and provide specific details about exact location (e.g., OSU Extension office XX county, conference room), and address.

Program _____ Location _____

Address _____ City _____ State _____ ZIP _____

Nature of Incident (Check all that apply.)

- ❑ Alcohol/Drugs
- ❑ Argument
- ❑ Behavior Problem
- ❑ Equipment/Property Damaged
- ❑ Facility Emergency
- ❑ Fighting
- ❑ Fire
- ❑ Inappropriate Language
- ❑ Injury/Illness (see p. 2)
- ❑ Intruder
- ❑ Missing Person
- ❑ Theft
- ❑ Vandalism
- ❑ Weather Related
- ❑ Other (Describe)

Name of Participant(s) Involved in the Incident/Injury (Add additional pages as needed.)

Name _____

Phone (____) _____ (H, W, C)

Address _____

City _____ State _____ ZIP _____

Birthdate _____ Age _____ Gender ☐ Female ☐ Male

Check One ☐ 4-H Youth ☐ Volunteer ☐ Parent ☐ Visitor

☐ Other _____

Name _____

Phone (____) _____ (H, W, C)

Address _____

City _____ State _____ ZIP _____

Birthdate _____ Age _____ Gender ☐ Female ☐ Male

Check One ☐ 4-H Youth ☐ Volunteer ☐ Parent ☐ Visitor

☐ Other _____

Details of Incident/Injury (Describe in detail - what was/were the participant(s) doing at the time of the incident/injury; what was said/done, by whom to whom, when, how, etc., including loss or damage to property; add additional pages as needed.)

Nature of Suspected Injury or Illness ☐ N/A

(Check all that apply.)

Injury

- ❑ Bite-Animal _____
- ❑ Bite-Human
- ❑ Broken Bone
- ❑ Concussion
- ❑ Cut-requires stiches
- ❑ Dental
- ❑ Dislocation
- ❑ Puncture
- ❑ Spinal Injury
- ❑ Sprain/Strain
- ❑ Other (Describe)

Illness

- ❑ Allergic Reaction
- ❑ Collapse/Faint
- ❑ Diabetic Reaction
- ❑ Eye Related
- ❑ Heart (angina, arrest)
- ❑ Respiratory
- ❑ Seizure
- ❑ Other (Describe)

Care Rendered (Check all that apply.) ☐ N/A

- ❑ Participant gave self-care ☐ Participant left area, no information
- ❑ Referred to health services
- ❑ Attended by (list names):

  Staff _____

  Volunteer _____

  EMT _____

  Other _____
- ❑ EMS (ambulance) - Time Called ___:___ am/pm

  Time of EMS Arrival ___:___ am/pm *and* Departure ___:___ am/pm

Describe action taken by staff and/or EMS _____

_____

_____

- ❑ Transported to hospital/clinic -- Time of Departure ___:___ am/pm

  Time of Arrival at hospital/clinic ___:___ am/pm

  Transportation provided by _____

  Name of hospital/clinic _____

Witness(es) (Attach any documentation you have along with contact information of additional witnesses, as needed.)

Name _____

Phone (____) _____ (H, W, C)

Address _____

City _____ State ____ ZIP _____

Age _____ Gender ☐ Female ☐ Male

Check One ☐ 4-H Youth ☐ Volunteer ☐ Parent ☐ Visitor

☐ Other _____

Name _____

Phone (____) _____ (H, W, C)

Address _____

City _____ State ____ ZIP _____

Age _____ Gender ☐ Female ☐ Male

Check One ☐ 4-H Youth ☐ Volunteer ☐ Parent ☐ Visitor

☐ Other _____

Participant Emergency Contact/Parent/Guardian Contacted ☐ No ☐ Yes, as listed below

Name _____ Date/time ___/____/____; _____ am/pm

Name/title/signature of Person Completing This Report

_____

Printed Name Title Signature Date

Action Taken ☐ Documented, No Further Action Needed ☐ Referred to State Office, List who: _____

If the incident is related to child abuse/neglect, please also complete the child abuse and neglect incident report, found at https://go.osu.edu/reportchildabuse.

Blor, K. & Epley, H.K. 6/2015

American Income life insurance company

Special Risk Division

Claim Report Form

Must be completed by the **camp director, a **chaperone**, or a **group leader of the event** UNRELATED to the patient.**

Part 1

Policy # _____ **Serial #** _____ Dates Person Was Insured _____

Name of Policy Holder/Group _____

Part 2

Name of Patient _____

Patient Date of Birth _____ Age _____ Sex ❑ M ❑ F

Patient Home Address _____

City _____ State _____ ZIP _____

Patient/Parent/Guardian Phone Number _____

Patient/Parent/Guardian Email Address _____

Patient is:
- ❑ Camper/Member
- ❑ Counselor/Instructor
- ❑ Salaried Staff (Eligible Worker's Compensation)
- ❑ Summer Staff
- ❑ Volunteer Leader

Part 3: Injury — Illness Report

Date of Injury/Illness _____ Time _____ Group Activity _____

Nature of Injury or Illness _____

Was this condition already present before this person became insured? ❑ Yes ❑ No

If yes, please explain _____

Describe fully how and where injury occurred, or nature of illness and treatment:

If there was no medical treatment during insured period, was injury or illness reported to staff member? ❑ Yes ❑ No

Office Use:

Part 4: Verification Signature

This form is to be completed by the camp director, chaperone, or group leader of the event UNRELATED to the patient.

I hereby certify that this was a supervised group activity sponsored by the organization covered under this policy.

I was the ❑ Camp Director ❑ Chaperone ❑ Group Leader ❑ Other (define) _____ *(cannot be related to patient)*

Name of Camp/Club | Contact Name (Print) | Title

Signature | Daytime Phone | Email

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.

Contact the AIL Special Risk Division with questions.
Phone: 800-849-4820
Email: claimsSRD@ailife.com

Send completed claim form to:
Mail: AIL-SRD, PO Box 50158, Indianapolis, IN 46250
Email: claimsSRD@ailife.com
Fax: 317-849-2793

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Part 5: Assignment to Provider *Please include any unpaid medical bills*

Only complete to assign payment directly to provider for medical bills not paid by patient/guardian.

I hereby authorize American Income Life Insurance Company to pay benefits on the above claim to medical provider listed:

_____ is to be reimbursed.
Provider Name

_____
Provider Address

_____ _____ _____
City State ZIP

_____ _____
Signature of Insured Member, Parent, or Guardian Date

Part 6: Release of Medical Information Authorization

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically-related facility, insurance company, the Medical Information Bureau or other organization, that has any records of me or my health, to give to American Income Life Insurance Company or its reinsurers any such information with respect to illness, injury, medical history, consultation, or treatments which include alcohol, drug or chemical dependency treatment. Information received is for the purpose of evaluating this claim and determining our liability under your existing coverage with American Income Life Insurance Company. This authorization shall remain valid for one year. You have the right to receive a copy of this authorization upon request. A photographic copy of this authorization shall be as valid as the original.

_____ _____
Signature of Patient, Guardian, or Personal Representative Date

Contact the AIL Special Risk Division with questions.
Phone: 800-849-4820
Email: claimsSRD@ailife.com

Send completed claim form to:
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Email: claimsSRD@ailife.com
Fax: 317-849-2793

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American Income life insurance company

Special Risk Division

How to File a Claim

The claim report MUST be signed by a camp director, chaperone, or group leader of the policy holder who is UNRELATED TO THE PATIENT. Complete the entire claim report (Parts 1–6). Valid claim reports must contain the following information:

- Policy number and serial number
- Full legal name of the injured/ill person (patient)
- Patient's date of birth and age
- Current mailing address
- Patient/parent/guardian contact information
- Date of the incident (injury or illness)
- How injury was sustained OR nature of the illness
- Verification signature by camp director, group leader, or chaperone
- Signature for Release of Medical Information Authorization

Written notice of claim, or Claim Report Form, must be provided to the Company within 20 days from the date of the activity covered by this policy but no later than 90 days from the date of incident.

Eligible medical statements must be provided within one year from the date of treatment. For claim review, provide the following:

- Itemized statements, **including diagnosis and procedure codes,** for services rendered by physician or hospital
- Prescription receipts complete with patient's name, Rx number, name of prescription, and price
- If payment has been made, proof of payment along with an itemized bill (proof of payment would be a paid receipt from provider, credit card receipt, or cancelled check)
- Explanation of Benefits for claims paid by personal insurance

All submissions must be full page-high resolution scans from a printer or copier in PDF format. They must be submitted as attachments to the email. Pictures or photos of documents taken on a phone or camera will not be accepted.

NOTE — Part 5: Assignment to Provider of the Claim Report Form must be completed in order for payment to be made directly to the medical provider.

Mail, fax, or email the completed Claim Report Form **directly to the Company.** *DO NOT rely on medical providers to forward information.*

American Income Life Insurance Company
Special Risk Division
PO Box 50158
Indianapolis, IN 46250
Phone: 800-849-4820
Fax: 317-849-2793
Claims Department Email: claimsSRD@ailife.com
Website: AILSpecialRisk.com

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