Catlin Insurance Company, Inc.

Dental Accident Claim Form

Claimant's Statement

Administered by NBFSA, LLC
a Third Party Administrator

(Please print – Attach separate sheet if additional space required)

CLAIMANT'S STATEMENT

Claimant's Name_____ **Date of Birth** ___/____/____ **Sex:** □ **M** □ **F**

Claimant's Address _____ _____
(Street) (City) (State) (Zip)

Parent/Guardian Name _____ **Best Contact Phone No.: (** **)** _____

Name/City/State of school _____

Policy Number _____

CLAIM INFORMATION

Date and Time of accident _____/_____/_____ _____ □ AM □ PM

Please describe the location (playground, gym, etc.) and circumstances of accident (attach separate sheet if needed):

_____

_____

_____

_____

WE MUST RECEIVE EMERGENCY ROOM OR OTHER FIRST TREATMENT NOTE (URGENT CARE, DOCTOR'S OFFICE) AND ANY OTHER MEDICAL RECORDS TO DEMONSTRATE CARE AND TREATMENT OF ACCIDENT RELATED INJURIES.

FILING INSTRUCTIONS

- ►**THIS CLAIM FORM MUST BE RECEIVED WITHIN 90 DAYS OF THE DATE OF ACCIDENT.**
- ►**THE RESPONSIBLE PARENT/GUARDIAN SHOULD COMPLETE THIS PAGE IN FULL.**
- ►**THE ATTENDING DENTIST SHOULD COMPLETE THE ATTACHED DENTIST'S STATEMENT. THE DENTIST MAY SUBMIT THE FORM DIRECTLY TO OUR OFFICE, OR YOU MAY RETURN IT WITH THIS CLAIM FORM AND OTHER DOCUMENTS.**
- ►**WE MUST RECEIVE ITEMIZED BILLS. WE CANNOT CONSIDER BALANCE DUE STATEMENTS WHICH ARE TYPICALLY NOT ITEMIZED. YOUR PROVIDER MAY FILE DIRECTLY ON YOUR BEHALF.**
- ►**MAKE COPIES OF THE AUTHORIZATION TO RELEASE INFORMATION FORM BEFORE COMPLETING THE PROVIDER SECTION IF YOU PLAN TO HAVE DOCUMENTS FROM MORE THAN ONE PROVIDER SUBMITTED FOR CONSIDERATION OF THIS CLAIM. PLEASE CALL US IF YOU NEED ADDITIONAL FORMS. GIVE THE AUTHORIZATION FORM TO ANY PROVIDER WHOSE RECORDS YOU WOULD LIKE TO SUBMIT WITH YOUR CLAIM (IF APPLICABLE).***

RETURN ALL DOCUMENTS TO:

NBFSA LLC
PO BOX 24279
WINSTON-SALEM NC 27114

TOLL FREE CUSTOMER SERVICE (855) 955 - 6469

ASSIGNMENT OF BENEFITS / CLAIMANT SIGNATURE

I certify that the information provided above is true and that the circumstances of the accident are as described herein. I acknowledge receipt of the attached Fraud Warnings Disclosure, and I understand that the submission of information for the purpose of defrauding an insurance company may be subject to criminal investigation and or penalties.

_____ _____
Signature of Parent/Guardian/Responsible Party **Date**

I assign payment of benefits directly to the service provider(s) associated with this loss and who provide standardized billing forms which include service itemization, coding, billing address and business tax identification number (TID) for tax purposes.

_____ _____
Signature of Parent/Guardian/Responsible Party **Date**

Fraud Warnings Disclosure

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 may subject the person to criminal and civil penalties.(Not applicable in AL, AR, CO,DC, FL, KS, KY, LA,MD,ME,NJ, NM,NY, OH, OK,OR, PA, PR, RI,TN, TX,VA, VT, WA, and WV.)

In Arkansas, Louisiana, Rhode Island, or 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 maybe subject to fines and confinement in prison.

In 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.

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

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.

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

In 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 an insurer, purported insurer, or to or by a broker or any agent thereof, any written statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal 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 fraudulent insurance act and may be subject to criminal and/or civil fines or penalties.

In Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, informationconcerninganyfactmaterialtheretocommitsafraudulentinsuranceact, which is a crime.

In Maine, Tennessee, Virginia, or Washington: 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.

Catlin Insurance Company, Inc.

Dental Accident

Administered by NBFSA, LLC
a Third Party Administrator

ATTENDING DENTIST'S STATEMENT

DENTISTS PLEASE NOTE: THIS IS A LIMITED POLICY. YOU MAY NOT RECEIVE PAYMENT IN FULL FOR SERVICES RENDERED. BALANCES AFTER BENEFIT DISTRIBUTION ARE THE RESPONSIBILITY OF THE PATIENT.

IN ORDER TO BE PAID DIRECTLY, YOU MUST SUBMIT THIS QUESTIONAIRRE ALONG WITH STANDARDIZED BILLING FORMS WHICH CONTAIN ALL APPROPRIATE CODING, CHARGES, YOUR BILLING ADDRESS AND TAX IDENTIFICATION NUMBER.

PATIENT'S NAME:	REPORTED DATE OF INJURY:
DESCRIBE THE EXACT NATURE OF THE INJURY:	
DATE YOU FIRST TREATED THE PATIENT FOR THIS COMPLAINT: _____ / _____ / _____	
WERE THE EFFECTS OF THE INJURY IMMEDIATELY APPARENT? □ YES □ NO	IF NOT, WHEN DID THEY BECOME APPARENT?
HAVE YOU EVER TREATED THE PATIENT FOR A SIMILAR CONDITION? □ YES □ NO	IF YES, WHEN? PLEASE EXPLAIN:
HAS THE PATIENT FULLY RECOVERED FROM THIS SPECIFIC INJURY? □ YES □ NO	IF NOT, WHAT FURTHER TREATMENT DO YOU EXPECT TO PROVIDE?
IN YOUR PROFESSIONAL OPINION, WAS THIS CONDITION CAUSED SOLELY AND INDEPENDENTLY BY ACCIDENTAL INJURY? □ YES □ NO	IF NOT, PLEASE EXPLAIN ANY UNDERLYING MEDICAL CONDITION OR OTHER CAUSE YOU BELIEVE MAY HAVE CONTRIBUTED:
DESCRIBE THE CONDITION OF THE TOOTH PRIOR TO INJURY: □ SOUND/NATURAL □ FILLED □ CAPPED □ ARTIFICIAL □ OTHER _____	

Dentist must sign here:	Degree:		
Address:	City:	State:	Zip:
Date:	Tax Identification Number:		

TO EXPEDITE PROCESSING, YOU MAY RETURN THIS QUESTIONAIRRE, ALONG WITH YOUR VISIT NOTES AND STANDARDIZED BILLING FORMS, DIRECTLY TO THE CLAIMS ADMINISTRATOR AT:

NBFSA
PO BOX 24279
WINSTON-SALEM NC 27114
TOLL FREE CUSTOMER SERVICE (855) 955 – 6469
FAX (336) 760 – 4644

Catlin Insurance Company, Inc.

Administered by NBFSA
a Third Party Administrator

RELEASE OF INFORMATION

Authorization Form

INSURED INFORMATION

Insured's Name_____ Date of Birth _____/_____/_____ Gender ☐ Male ☐ Female

Insured's Address _____

Policy Number _____ Phone Number _____Social Security Number _____

I hereby authorize _____
(TREATING FACILITY/ PHYSICIAN/OTHER HEALTHCARE PROVIDER NAME HERE)
and its affiliates, employees and agents to release health information which identifies diagnosis, treatment, claims payment and healthcare services already provided or to be provided to:

_____ for _____
(Patient's full name) (dates of treatment)

Information should be released or mailed to: ☐ Individual ☐ Physician ☐ Institution ☑ Insurance Administrator

NBFSA LLC, on behalf of XL Catlin **PO Box 24279** **Winston-Salem NC 27114**	**Purpose:** **☑ Claims Payment ☐ Litigation** **☐ Medical Review ☐ Other:_____**

I request only the following information be released:

☐ ENTIRE MEDICAL RECORD ☐ Lab reports ☐ Operative Report ☐ X-Ray Report
☐ Emergency Room Report ☐ Pathology Report ☐ EKG ☐ X-Ray Film
☐ Admission History & Physical ☐ Cardiac Cath Lab Reports ☐ Itemized Billing Statement
☐ Discharge Summary ☐ Other _____

I understand this release includes personally identifiable information such as name, address, social security number and insurance identification number. I also understand that this information may be subject to re-release by this entity for the purpose of resolving insurance benefit coverage determinations. As such, this information may no longer be protected by applicable state and/or federal privacy laws.

This authorization shall be valid for one year (365 days) from the date of my signature below or until _____.
(insert date)

I have the right to revoke this authorization by providing written notice to the receiving entity listed above. However, this authorization may not be revocable if the entity, its employees or agents have already acted on this authorization prior to receiving my written revocation. I understand that this authorization is voluntary, and that I have a right to a copy of this authorization. Refusal to sign this authorization does not affect my eligibility for enrollment or payment of covered services.

Member Signature: _____ **Date**: _____
(If other than member, please sign below and include a copy of written proof of legal authorization to represent the member or his or her estate (i.e. Power of Attorney, Guardianship, Executor, other)

Name of Legal Representative, if applicable: _____

Signature of Legal Representative: _____ Date: _____

Name of Witness, if signed by Representative: _____

Signature of Witness, if signed by Representative: _____ Date: _____