ACCIDENT INSURANCE – PROOF OF LOSS

Insurance coverage is underwritten by StarNet Insurance Company (domiciled in Iowa - California Certificate of Authority #6978), 2445 Kuser Road, Suite 201, Hamilton Square, NJ 08690.

MAIL CLAIM TO: **Health Special Risk**
8400 Belleview Drive, Suite 150, Plano, Texas 75024
Phone: (972) 512-5600 Fax: (972) 512-5820
Toll Free: (866) 523-3269 Email: Berkley@HSRI.com

POLICYHOLDER: Assure Child Care	**POLICY NUMBER:** PAI V00100168
POLICYHOLDER ADDRESS: IDS Center, Suite 700, 80 South 8th St., Minneapolis, MN 55402	
CHILD CARE PROVIDER:	
CHILD CARE PROVIDER ADDRESS: Street: City: State: Zip:	
NAME OF INJURED PERSON:	**DATE OF BIRTH:**
SEX: ☐ **MALE** ☐ **FEMALE**	**INJURED PERSON TELEPHONE (IF OVER AGE 18):**
SOCIAL SECURITY # OF INJURED PERSON: *Please note that the Injured Person's Social Security Number* ***MUST*** *be provided as required by the Center for Medicare Services.*	
ADDRESS OF INJURED PERSON: Street: City: State: Zip:	

IF THE INJURED PERSON IS UNDER 18 OR OTHERWISE DEPENDENT, GIVE THE FOLLOWING INFORMATION:

Name of Father or Male Guardian _____ Social Security Number _____

Address _____ Telephone Number _____

Name of Mother or Female Guardian _____ Social Security Number _____

Address _____ Telephone Number _____

NATURE OF INJURY: (Please describe and fully indicate what part of the body was injured – e.g., broken arm, sprained ankle)

DESCRIBE HOW THE ACCIDENT OCCURRED. Please provide all details. **Must be a bodily injury accident.**

DID ACCIDENT OCCUR:

While claimant was policyholder supervised? ☐ YES ☐ NO
During a policyholder sponsored activity? ☐ YES ☐ NO
Place of Accident: _____

Date of Accident: _____
Time of Accident: _____ AM _____ PM
First Treatment Date: _____

Name and Title of Person Supervising Activity: _____

Witness to Accident: _____

IS THE INJURED PERSON COVERED UNDER ANY OTHER HEALTH AND/OR ACCIDENT INSURANCE PLANS? ☐ YES ☐ NO

IF YES, PLEASE PROVIDE THE FOLLOWING:

Name of Other Insurance Company(ies)	Address of Other Insurance Company(ies)	Policy Number(s)	Name of Policyholder(s)

AUTHORIZATION TO RELEASE MEDICAL INFORMATION: I hereby authorize any physician or medical practitioner, hospital, other organization, institution, or person that has any medical records or knowledge of me or my family as diagnosis, treatment, and prognosis regarding any physical, mental, drug or alcohol condition of any and all such information to be given to Berkley Group Companies: Berkley Life and Health Insurance Company, StarNet Insurance Company, Acadia Insurance Company, Great Divide Insurance Company, or its authorized Administrators or their legal representatives.

Any information obtained will not be released by the Company, except to persons or organizations performing business or legal services in connection with my claim. A photocopy of this authorization shall be valid as the original and is valid for 24 months from the date shown below (In CA, CT, GA, HI, MA, MN, NC, NJ, OH, and VA authorization shall be valid during the duration of the claim). I understand that my authorized representative or I will receive a copy of this authorization upon request.

DECLARATION: These statements are true and complete to the best of my knowledge.

Warning: 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. **FOR RESIDENTS OF NEW YORK:** 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.
(Fraud language varies by state. Please see below.)

Printed Name of Claimant or Authorized Representative _____ Relationship _____

Signature of Claimant or Authorized Person _____ Date _____

FRAUD WARNING

FOR RESIDENTS OF 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.

FOR RESIDENTS OF 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.

FOR RESIDENTS OF CALIFORNIA: For your protection California law requires the following to appear on this form:

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.

FOR RESIDENTS OF 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.

FOR RESIDENTS OF DELAWARE AND IDAHO: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information is guilty of a felony.

FOR RESIDENTS OF 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.

FOR RESIDENTS OF 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.

FOR RESIDENTS OF KANSAS: 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 may be guilty of insurance fraud as determined by a court of law and may be subject to fines and confinement in prison.

FOR RESIDENTS OF 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, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

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

FOR RESIDENTS OF MAINE, TENNESSEE, VIRGINIA AND 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.

FOR RESIDENTS OF MINNESOTA: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

FOR RESIDENTS OF 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.

FOR RESIDENTS OF NEW JERSEY: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

FOR RESIDENTS OF 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.

FOR RESIDENTS OF OHIO AND OKLAHOMA: 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.

FOR RESIDENTS OF OREGON: 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 may be guilty of a crime and may be subject to fines and confinement in prison.

FOR RESIDENTS OF PENNSYLVANIA: 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.

FOR RESIDENTS OF PENNSYLVANIA: 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.

FOR RESIDENTS OF VERMONT: Any person who knowingly presents a false statement in a claim for proceeds of an insurance policy may be guilty of a criminal offense and subject to penalties under state law.