IMPORTANT! PLEASE READ!

Student Athlete Accident Form (SAAF)

Student Athletic (Sports) Accident/Injury Excess Secondary Insurance Benefit Plan

ADL RISK SERVICES, LLC

PARENT/LEGAL GUARDIAN IS RESPONSIBLE FOR SUBMITTING THIS FORM WITHIN 90 DAYS FROM THE *INITIAL* DATE OF INJURY!
DO NOT WAIT TO BE BILLED BY THE PROVIDER(S) BEFORE SUBMITTING THIS FORM!

ATTENTION:
SUBMIT THIS FORM & CLAIMS TO:

Plan Administrator
ADL Risk Services, LLC
556 Clay Street
Montgomery, AL 36104
Phone: 844.350.9897
Secure Fax: 334.649.7901
Email: Claims@adlrs.com
Website: http://adlrs.com

This form must be fully and accurately completed and submitted to ADL Risk Services (ADL) on or after the date of injury, and no later than 90 days from the initial date of injury, to avoid denial of your claims. Benefit eligible/covered expenses will be paid only when they are in excess of other valid insurances. Your medical provider must file your claim with all other available and collectible insurances prior to filing with ADL. Please provide all medical providers where treatment was/will be received with ADL Risk Services' billing address and contact information, as your secondary, excess, student accident medical insurance, to be billed directly once any applicable primary/other insurance has paid. The medical provider must submit the HCFA 1500 and/or UB-04 form along with your primary insurance Explanation of Benefits (EOB). **Please read the Accident Medical Claim Filing Instructions thoroughly and completely prior to submitting this form or filing any claims. The claim filing instructions are included with the student accident form that have been provided to the School District(s).** ***NOTE:*** *To* avoid a denial of your claim(s), please ensure the above and following criteria are met. Medical treatment must commence within 30 days of the initial injury date by a licensed medical doctor. (*Or within 72 hours, if Emergency Room treatment is required*.) Each injury has a one-year (52 Week) benefit period. All medical claims must be filed as soon as possible, and no later than 180 days after the injury benefit period ends, or your claim(s) will be denied. The Plan Benefits are limited and may not provide 100% Coverage, especially if your primary insurances' annual out of pocket deductible or co-insurance requirements have not been met. ***This is a Student Athletic Accident Excess Benefit Plan, NOT a comprehensive, major medical health insurance plan/policy nor an alternative to a major medical health insurance plan/policy.*** **Please retain a copy for your records.**

Section 1: School Notification of Injury Report

(Section 1 Must be completed and signed by an Authorized School Official)

Name of School District (*Planholder*): RICHLAND SD ONE, SC

School District Plan ID/Policy No.: SC2019-20-01-101

Name of School Student Attends:

School Phone No.:

Name of Injured Student (*First, Middle, Last):*

Social Security# *(Last four):*

☐ Male ☐ Female

Date of Birth:

Age:

Grade:

Date of Injury:

Body Part(s) Injured: ☐ Left ☐ Right

Place of Injury:

Time of Injury: ☐ A.M. ☐ P.M

Name of Activity or Sport:

At the time the injury occurred, was the accident witnessed? ☐ Yes ☐ No
If "YES", by whom?

At the time of the accident, was the student involved in an activity sponsored and supervised by the Planholder? ☐ Yes ☐ No

At the time of the accident, was the student traveling to or from a regularly scheduled school activity? ☐ Yes ☐ No

How did the injury occur? *(Explain in detail)*

Name of School Official *(Print):*

Phone No.:

Title:

Email:

Signature of School Official:

Date Signed:

Section 2: Student Insurance Information

(Section 2 & 3 Completed by the Parent/Legal Guardian. If student has no insurance, write "None")

Is the Student covered by any other insurance plan/policy, either as a dependent, or under a group, individual, automobile, medical or liability policy? ☐ Yes ☐ No *Is this ☐ Individual ☐ Group*

Name of Insurance Carrier:

Name of Policyholder:

Policy/Plan No.:

***Is student covered by both parent/guardian insurance plans? * ☐ Yes ☐ No**
(If "yes", please add policyholder (#2) insurance information below.)

Name of Insurance Carrier (2):

Name of Policyholder (2):

Policy/Plan No:

Is the above insurance a Medicaid Plan or other government insurance? (i.e., Tricare) ☐ Yes ☐ No *If "YES", please enter Policy/Plan No. above. *

Section 3: Parent/Guardian Statement

(Section 2 & 3 MUST be completed by the Parent/Legal Guardian)

Name of Father/Legal Guardian: (*Please print legibly*)

Father/Legal Guardian Phone No.:

Father/Legal Guardian Email:

Is the father/Legal Guardian employed? ☐ Yes ☐ No

Father/Legal Guardian Employer:

Name of Mother/Legal Guardian: (*Please print legibly*)

Mother/Legal Guardian Phone No.:

Mother/Legal Guardian Email:

Is the mother/Legal Guardian employed? ☐ Yes ☐ No

Mother/Legal Guardian Employer:

Parent/Legal Guardian Mailing Address (*Street address, City, State, Zip Code*):

Section 4: MEDICAL INFORMATION AUTHORIZATION AND ASSIGNMENT OF BENEFITS

MEDICAL INFORMATION AUTHORIZATION & ASSIGNMENT OF BENEFITS: I authorize any Health Care Provider, Medical Facility, Doctor, Insurance Company or Organization to furnish at the request of ADL Risk Services, LLC or the underwriting companies with which it works, information which you may possess including, findings and treatments rendered, and copies of all hospital and medical records for professional services and hospital care rendered on my behalf. The foregoing authorization is granted with the understanding that any legal rights I may ordinarily have to claims communications between us as privileged are hereby expressly and voluntarily waived. A Photostat of this authorization shall be considered as valid and effective as the original. Payments will be made to the providers of service, unless a paid receipt/statement accompanies the medical claim submission. Any person, who knowingly and with intent to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information, is guilty of a felony.

STUDENT NAME *(Print):*

SIGNATURE OF PARENT/GUARDIAN:

DATE SIGNED:

(Section 4 MUST be signed by the Parent/Legal Guardian)

SAF.1116rev23

PLEASE PROVIDE A COPY OF THIS FORM TO ALL PROVIDERS WHERE TREATMENT IS OR WAS RECEIVED!
If you would like to receive your Explanation of Benefits(EOB) from ADL electronically via email, please contact our office.