

GROUP ACCIDENT CLAIM FORM

GROUP ACCIDENT PROTECTION PLANS

Underwritten by: BCS Insurance Company, Chicago, IL

Administered by: North American Benefits Company

Mail to:



NORTH AMERICAN BENEFITS COMPANY
 P.O. Box 3056
 Southeastern, PA 19398-3056
 1-800-994-GAPP

The front and back of this form should be completed by the employee and the employer.

Is this a claim for: Disability <input type="checkbox"/>		Health Insurance <input type="checkbox"/>		(Check one or both)		COMPLETE BACK SIDE OF FORM.		
Insured Employee's Last Name		First Name		Initial		Date of Birth	Social Security #	Sex
Insured's Address (Street, City, State, Zip)								
Name of Employer (as on Monthly Billing Address)				Group #		Occupation		Wages

EMPLOYER'S STATEMENT

(MUST BE COMPLETED BY THE EMPLOYER ON ALL CLAIMS. IF SELF-EMPLOYED, COMPLETE ON SELF.)

Name of Employee			Employee's Salary		
Was this injury caused by or related to any gainful Employment of the Claimant <input type="checkbox"/> Yes <input type="checkbox"/> No		Date Claimant last worked		On what date did you or do you expect to resume work?	
Employment Status <input type="checkbox"/> ACTIVE <input type="checkbox"/> TERMINATED <input type="checkbox"/> RETIRED <input type="checkbox"/> TEMP. LAYOFF <input type="checkbox"/> LEAVE OF ABSENCE					
Date Employed		Date Last Worked		Date of Termination, Retirement or commencement of Layoff, Disability or Leave of Absence	
Was this Disability caused by or related to any employment of the Claimant for Wage or Profit? <input type="checkbox"/> Yes <input type="checkbox"/> No		Claimant covered by Worker's Compensation? <input type="checkbox"/> Yes <input type="checkbox"/> No		Was this claim filed with Worker's Compensation? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Date Accident Occurred		Nature of Injury			

If injured, How, Where and at What Time did Accident Occur? (If more space is required, use remarks section on back of form.)

Date of First Medical Treatment		Where? (Hospital, Doctor's Office)	
Name and Full Address of First Physician Consulted			
Give FULL Names and Addresses of ALL Other Physician's Consulted During the Past 3 Years			
1.			
2.			
Who was the supervisor in charge at time of accident?		When did supervisor know of this accident?	
Is this injury a result of equipment failure? <input type="checkbox"/> Yes <input type="checkbox"/> No		Does injured employee wish medical treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Supervisor to obtain names and phone numbers of 2 witnesses.			

AUTHORIZATION

I/we jointly certify that the information is true and correct to the best of my knowledge. I/we hereby authorize any physician, medical practitioner, hospital, clinic other medical or medically related facility, insurance or reinsuring company, consumer reporting agency, or employer having information available as to diagnosis, treatment or prognosis with respect to any physical or mental condition and/or treatment of me or my minor children and any other non-medical information of me and my minor children to give to BCS Insurance Company, or its legal representative, any and all such information.

I understand the information obtained by the use of this Authorization will be used by BCS Insurance Company to determine eligibility for benefits under the Group Policy. Any information obtained will not be released to any person or organization except insurance companies, or any other persons or organizations performing business or legal services in connection with my claim, or as may be otherwise lawfully required or as I may further authorize.

I know that I or my authorized representative is entitled to receive a copy of this Authorization. I agree that a photographic copy of this Authorization is as valid as the original and that it shall be valid until the final disposition of the claim to which it relates.

Employee's Signature		Date		Dependent's Signature	
Employer's Signature		Date		Official Position	

ANY SITUATION AND/OR INJURY SHOULD BE PROMPTLY REPORTED TO GAPP MANAGED CARE
PHONE: 1-800-994-GAPP OR FAX: (610) 995-0181

REIMBURSEMENT AGREEMENT

WHEREAS, the undersigned is insured under the carrier administered by North American Benefits Co., and

WHEREAS, the undersigned has or will file a claim for benefits in connection with his or her accident, and

WHEREAS, pending determination of any recovery of proceeds from or on behalf of the responsible party, or any other plan providing benefits, the undersigned has requested NABCO to approve his or her claim subject to the following agreement.

I will promptly repay the employee benefit plan if and when I receive payment(s) for the injury or sickness from or on behalf of the responsible party or any other plan providing benefits. NABCO shall be reimbursed to the extent of its payment under the employee benefit plan. If any balance then remains from such recovery, it shall be applied to reimburse the Member and any other plan providing benefits to the Member as their interests may be apportioned and borne by all parties in interest in the ratio of respective recoveries; provided, that if there is not recovery in any proceeding instituted and conducted solely by this plan, it shall bear expenses thereof.

Date _____ Signature Employee _____

RIGHT OF SUBROGATION AND REFUND

When this provision applies. You may incur medical expenses due to injuries for which benefits are paid by the Policy. We will be subrogated to all rights you may have against that other person. You must repay to us out of the recovery made from: (a) the other person; or (b) the other person's insurer.

Amount subject to subrogation or refund. Only the amount recovered for medical charges will be subject to subrogation or refund. One-third of the new recovery will be deemed to be for medical expenses. However, in no case will the amount subject to subrogation or refund exceed the amount of medical benefits paid for the injury under the Policy.

Defined Terms: "Recovery" means: monies paid to you to compensate for losses caused by the injuries. "Net Recovery" means: our right to pursue your claims for medical charges against the other person. "Refund" means: repayment to us for medical benefits paid.

Recovery from another insurer of you. This right of subrogation and refund also applies when you recover under an uninsured or underinsured motorist plan.

Before we can complete our consideration of the charges submitted, we require additional information. Please supply us with the following information (to the best of your knowledge).

1. Name and address of (third/other party involved):

I have reviewed the attached clause and I have answered all questions fully.

Date _____ Signature Employee _____

REMARKS: